



**PERCEPTIONS OF MENTAL HEALTH CARE USERS ON THE
CONTRIBUTION OF THE INTERACTIVE GROUPWORK MODEL
IN OCCUPATIONAL THERAPY GROUPS
TO THEIR RECOVERY**

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ABSTRACT

Background

Mental health disorders account for a significant portion of the burden of disease in South Africa and places a substantial strain on the national mental health care system. Mental health care policy and service trends advocate for client-centred practices, whereby the needs and perspectives of the population being served are taken into account in the design and delivery of interventions. Mental health disorders affect people's performance of and participation in the occupations of daily life. The profession of occupational therapy (OT) values client-centred practice and seeks to offer interventions that are closely aligned with the occupational and related recovery concerns of mental health care users (MHCUs). The Interactive Groupwork Model (IGM) is an unpublished, South African OT model that is used to guide groupwork interventions in mental health care settings. It serves as the basis for a position statement on the role and scope of the profession in groupwork issued by the Occupational Therapy Association of South Africa (OTASA, 2014).

Research Problem

To date there is little literature documenting service users' perspectives on groupwork in occupational therapy within the South African context. In particular, there is no published South African research in occupational therapy regarding mental health service users' (MHCUs) perspectives on the contribution of groups run according to the IGM to their recovery.

Research Purpose

This study contributes to the refinement of the Interactive Groupwork Model as one of a number of approaches to groupwork used by occupational therapists in South Africa. The information gained from the research will assist in creating relevant group based programmes for mental health care users who get admitted to mental health services where occupational therapy groups based on the IGM are offered.

Research Question

How do mental health care users perceive the contribution of the IGM to their recovery?

Research Aim

To describe the perspectives of users of mental health services about the contribution of IGM used in occupational therapy, to their recovery within a specialised psychiatric unit.

Research Objectives

Describe the perspectives of MHCUs on the benefits of IGM for their recovery

Describe the perspectives of MHCUs on the limitations of IGM for their recovery

Describe the recommendations of MHCUs on the refinement of the IGM

Research Design & Methodology

A descriptive qualitative design positioned in a social constructivist paradigm guided the study methodology. Purposive maximum variation sampling was used. Data was collected using semi structured interviews with seven mental health care users during an eight or twelve-week admission period, at different stages of their recovery and community re-entry. Data was audio recorded and transcribed. Thematic analysis enabled the opinions of informants to be sub-categorised and categorised. Ethical principles of beneficence, non-maleficence, autonomy and justice were upheld throughout the research process.

Findings

Participants' perspectives on the contribution of occupational therapy groups using the IGM to their recovery was reflected in a single theme: "helping me to navigate life while living with my illness". The theme was supported by two categories: "learning through the group space" and "learning that the journey is never over". The learning that occurred in each category was supported by five sub-categories, each reflecting a dimension of how IGM based occupational therapy groups helped participants towards recovery: "engaging in the activity", "participating in the group process", "experiencing the group structure", "recognising personal shifts" and "acknowledging stuckness".

Conclusion

The research provided practice based evidence of service user perspectives on occupational therapy groupwork using the IGM. The IGM is beneficial as a change modality as it assists MHCUs with self-learning and addresses the interpersonal aspect of recovery during the acute intervention phase. With refinements considering the occupational human, and embracing the recovery philosophy, the IGM may offer greater value to MHCUs by addressing broader occupational engagement concerns that extend post discharge. The relevance of the IGM to the post discharge recovery of MHCUs warrants attention if occupational therapy is to play a role in supporting MHCUs to live meaningful and productive lives through occupation. Recovery from serious mental illness is a complex lifelong process that is facilitated when health care professionals collaborate with MHCUs. Revisions to the OTASA position statement are suggested in an attempt to ensure that the OTASA position statement on groupwork represents a broader understanding of groupwork in the profession and specifically in mental health.

Key words

Integrated Groupwork Model, Groupwork, Mental Health, Occupational Therapy, Recovery

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DEFINITION OF TERMS

1. **Client:** the entity that receives occupational therapy services (Moyers & Dale, 2007, p. 659).
2. **Client-centred practice:** an approach to occupational therapy which embraces a philosophy of respect for and partnership with people receiving services. Client centred practice recognises the autonomy of individuals and the need for client choice in making decisions about occupational needs, the strengths clients bring to a therapy encounter, the benefits of client-therapist partnership and the need to ensure services are accessible and fit the context in which a client lives (Law, Baptiste, & Mills, 1995, p.253)
3. **Group:** an aggregate of people who share a common purpose which can be attained only by group members interacting and working together (Mosey, 2014, p. 25).
4. **Groupwork¹:** Groupwork_provides a context in which individuals help each other, it is a method of helping groups as well as helping individuals; it can enable individuals and groups to influence and change personal, group, organisational and community problems (Becker, 2005, p. 13).
5. **Interactive Groupwork Model (IGM):** a model to guide the practice of occupational therapy groupwork created by M. De Beer & C. Vorster in the 1980s at the University of Pretoria (OT Grow, 2014).
6. **Mental health:** a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (World Health Organization, 2014, p.1).
7. **Mental health care practitioner:** a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services (South African National Department of Health, 2014, p. 7).

¹ The Integrated Groupwork Model (IGM) uses the term groupwork as one word to describe the concept. Groupwork as one word will be used in this report to reflect the concepts of the model.

8. **Mental health care user (MHCU)**- a person receiving care, treatment and rehabilitation services under the South African Mental Health Care Act 17 of 2002 (South African Government, 2002, p. 6).
9. **Mental illness**: a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis (South African Government, 2002, p. 6).
10. **Occupational therapy (OT)**: a health profession concerned with promoting health and wellbeing through occupation. The primary goal of OT is to enable participation in everyday life (World Federation of Occupational Therapy, 2013, p.4).
11. **Occupation**: the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do (World Federation of Occupational Therapy [WFOT], 2017, p.1).
12. **Occupation based practice**: usually understood as an intervention that supports clients' interests, needs, well-being and participation in everyday life through occupation (American Occupational Therapy Association, 2014, p. 625).
13. **Perception**: a mode of apprehending reality and experiencing it through the senses, thus enabling discernment of figure, form, language, behaviour, and action. Individual perception influences opinion, judgment, understanding of a situation or person, meaning of an experience, and how one responds to a situation (Munhall, 2012).
14. **Personal recovery**: a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of illness (Anthony, 1993, p. 527).
15. **Psychosocial disability**: a state where individual or collective sense of incapacity restricts optimal use of individual and collective human agency (Jose, Cherayi, & Sadath, 2016).
16. **Psychosocial rehabilitation**: mental health services that bring together approaches from the rehabilitation and the mental health fields, combining pharmacological treatment,

skills training, and psychological and social support to clients and families in order to improve their lives and functional capacities (South African National Department of Health, 2014, p. 7).

- 17. Recovery model:** an approach to mental health care and rehabilitation which holds that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem, identity and on attaining meaningful roles in society (South African National Department of Health, 2014, p. 7).

ACRONYMS/ABBREVIATIONS

DSM IV-R	: Diagnostic Statistical Manual of Mental Disorders (version 4 revised)
DSM V	: Diagnostic Statistical Manual of Mental Disorders (version 5)
NDOH	: National Department of Health of South Africa
FSDRSSA	: Framework and Strategy for Disability and Rehabilitation Services in South Africa
HC2030	: Healthcare 2030
IGM	: Interactive Groupwork Model
NHI	: National Health Insurance
NMHPSF	: National Mental Health Policy and Strategic Framework
MHCU	: Mental Health Care User
MHCP	: Mental Health Care Provider
OT	: Occupational Therapy/ Occupational Therapist

CHAPTER 1: INTRODUCTION

1.1 Introduction to the study

Post-apartheid South Africa faces a high prevalence of mental disorders and a public mental health service that is fragmented, grossly under-resourced and inequitable (Lund, 2012). With so many individuals affected by mental health problems who require psychiatric treatment, there is a growing need for occupational therapy intervention at both in and out-patient levels of mental health care (Sundsteigen, Eklund, & Dahlin-Ivanoff, 2009) Drum, Swanbrow, Becker & Hess, 2011; McCarthy & Hart, 2011). One particular occupational therapy groupwork approach, called the Integrated Groupwork Model (IGM) (OTGrow, 2014), is used in South African public sector mental health units. The perspectives of adult service users about the contribution of IGM to their mental health recovery was explored in this study. The IGM is a structured method of running activity-based occupational therapy groups. It was designed and is marketed amongst mental health clinicians through in-service training by a collective of South African occupational therapists, called OTGrow.

Mental health is described by the World Health Organisation (WHO) as a state of wellbeing where the individual realizes their own abilities, can cope with normal life stressors, function effectively and contribute to society (World Health Organization, 2014). Mental health disorders comprise of a broad range of problems with symptoms including abnormal thoughts and an inability to regulate emotions and behaviour (World Health Organization, 2014). An increase in mental disorders is noted globally with the WHO predicting that unipolar depression will be the second leading diagnosis by the year 2020 (World Health Organization, 2011). Mental health disorders such as depression and psychotic disorders also account for a significant portion of the disease burden in South Africa, placing an increased demand for accessible, affordable and effective mental health services (Jack, Wagner, & Petersen, 2014; Lund et al., 2010). Substance use within the South African context is rife, and on the increase. Alcohol and other illegal substance abuse increases the mental health concerns of the general

population as well as those with existing mental health conditions (Parry, 2015). Greater equity in mental health services is indicated because large groups of South Africans remain disadvantaged by mental health service disparities inherited from the apartheid government (Benatar, 2013). Given the scope of the demand for mental health services, it becomes important to investigate intervention strategies such as groupwork, that provide people-centred care to as many people as possible with available human, financial and other resources (Drum et al., 2011; McCarthy & Hart, 2011; World Health Organization, 2016) .

The increased demand for equitable and people-centred mental health services in South Africa is being addressed through the re-engineering of public mental health care. Amongst other policies², this process is being guided by the National Mental Health Policy Framework and Strategic Plan 2013-2020 (NMHPFSP) (National Department of Health [South Africa], 2013). In alignment with the Alma Ata Declaration on primary health care, the NMHPFSP asserts that mental health is fundamental to achieving the goal of “a long and healthy life for all South Africans” (South African National Department of Health, 2013, p. 3). An objective of the NMHPFSP is to strengthen mental health system effectiveness by moving towards National Health Insurance (NHI) (National Department of Health (South Africa), 2015). The NHI aims to address the inequalities between the public and private health systems in South Africa (Matsoso & Fryatt, 2013). The types of mental health services on offer in both sectors therefore warrant investigation, including the use and therapeutic benefits of group-based interventions by occupational therapists. While the use of the IGM was investigated in a public mental health inpatient occupational therapy setting only, its findings also pertain to occupational therapists in the private sector that use it to guide their group-based interventions.

The services provided by occupational therapists working in public and private mental health care sectors should align with the NMHPFSP, including the increasing emphasis on collaborative engagement with service users to promote quality assurance

² National Health Act (2003)
Quality Health Care for South Africa (2007)
Mental Health Care Act (2002)

of interventions (Rispel et al., 2010). The use of group based interventions as opposed to individual psychotherapy has been proposed as a strategy to meet ever increasing mental health service demands and attain greater equity in mental health services (Drum et al., 2011; McCarthy & Hart, 2011) yet very little research has been done by South African occupational therapists on the use and benefits of groups in inpatient treatment settings. Knowing more about mental health care users' (MHCU) perspectives on occupational therapy groupwork will begin to align the profession with current mental health and PHC re-engineering policy imperatives in South Africa.

1.2 Towards inclusive mental health service design

Inclusive mental health service design refers to the designing of services which are useable and desirable from the users perspective as well as efficient and different from the organizations' perspective (Aceves-Gonzalez, Cook, & May, 2014). In past years medicine has had a paternalistic culture in society. While professionals listened to their patients concerns, their treatment was guided by medical perspectives and treatment. Patients were expected to follow this advice. This type of paternalistic culture often dismissed patient perspectives, and would not take kindly to objections or dissimilar opinions (Jacob, 2015). Historically mental health care users (MHCUs) have not been given the opportunity to voice their service preferences in comparison to those living with physical disabilities, especially regarding the treatment methods used by professionals to address their needs (Kleintjes, Lund, & Swartz, 2013). Marginalisation, prejudice, stigmatisation, social exclusion and isolation are directly related with having a mental health disorder (Kleintjes et al., 2013). These social consequences of ill mental health are compounded when MHCUs are excluded from the monitoring and evaluation processes that are required by state departments to ensure user friendly services and people centred health care (Kleintjes et al., 2013). In order to align with South African policy, the voices of the MHCUs must be heard. Practice based evidence will be enhanced when the perspectives of patients on the types of intervention used to assist their recovery are taken into consideration during service design. Interventions may include treatment modalities such as medication, social support, individual and group based psychotherapy and occupational therapy

(Jhanjee, 2014). There is currently limited documented research in the South African and international occupational therapy literature about the perspectives of MHCUs on the use of groupwork in mental health occupational therapy as a therapeutic modality. With this in mind, the study is therefore well positioned as it explored the perspectives of the MHCUs who have been exposed to an indigenous occupational therapy groupwork model of South Africa.

1.3 OTASA position statement on groupwork

The Occupational Therapy Association of South Africa (OTASA) has embarked on the development of a series of position statements in relation to key national policies. OTASA (2014) issued a position statement on groupwork in occupational therapy, stating the association's position to occupation focused groupwork and its relation to the scope of practice, particularly in mental health care (see Appendix A). In the position paper, occupation as the primary focus of practice for the profession and the unique contribution it can offer to MHCUs are highlighted. The position paper contains many similarities to the IGM and the core concepts of the model, which are described later in chapter two. OTASA confirms that occupational therapists are experts in the use of occupation as means and as end in facilitating health and promoting participation in meaningful roles. The position statement further serves in guiding occupational therapists to define, plan, present and evaluate their groups in mental health settings (Occupational Therapy Association of South Africa, 2014). Four criteria for occupation focussed groups that emerged from occupational therapy groupwork are identified in the position statement, with specific reference to mental health care: a focus on occupation, a clear goal for the group, an activity is presented and that questions are intentional and specific. A focus on occupation, as described in the position paper, refers to the objectives of groups in addressing occupational dysfunction. An emphasis is placed in socialisation and social skills in mental health. With regards to a clear group goal the key aspects highlighted are that the goals are selected specifically with regards to group members' problem areas. A presentation of activity refers to such activities, tasks or occupations as games, pen and paper exercises, drama, drawing, crafts, activities of daily living (ADL) and work. Once the

occupational therapist has selected the goal for the group, an appropriate activity is chosen to allow the goal to be achieved through participation in the activity. Group members are afforded the opportunity to practice problem solving and social skills within a 'here-and-now' context. Intentional questions related to interpersonal dynamics arising from the 'here-and-now' behaviours in the group are recommended, for example, identifying "what" these behaviours are and used by or direct to "whom" in the group and "why". The questions are aimed at facilitating reflection and insight into each group member's experience and relational behaviours.

Taking the notion of inclusive service design forward, it is appropriate to consider the perspectives of MHCUs on groupwork when crafting a position statement such as the one issued by OTASA (2014). Practice becomes aligned with position statements when the perspectives of clients about the recovery-orientated outcomes of intervention methods are taken into consideration. By including clients' evaluation of intervention methods, they begin to play a central role in their own treatment planning and recovery process. Although the position statement on groups (Occupational Therapy Association of South Africa, 2014) indicates that evidence based research in occupational therapy is occupation-based and crucial for the profession to progress, no research has yet emerged about groupwork in specialist psychiatric units. While clinicians render client-centred services that are monitored and evaluated through basic standards of practice, they do not necessarily have the time to conduct empirical research into the perspectives of their clients on the impact of occupational therapy on recovery. OTASA (2014) has called on training and education programmes to encourage research in this area creating an opportunity for the current study to contribute to the body of knowledge required for consumer informed position statements and services.

1.4 Groupwork: promoting therapeutic outcomes and recovery for mental health service users

Mosey (1973) defines a group as "an aggregate of people who share a common purpose, which can be attained only by group members interacting and working

together”(Gibson, 1988). A therapeutic group is however more than just people that happen to be doing the same thing at the same time in the same place; to be a group, the people must have some connection, some way in which they come together with a common purpose or function, with the potential of effecting change within members and the group (Barnes, Ernst, & Hyde, 1999). Interpersonal connection defines the boundaries of a group, separating it from the surrounding environment of which it also is a part (Barnes et al., 1999). The use of groups for the attainment of therapeutic outcomes has been extensively documented in professional literature including psychology (van Knippenberg, Haslam, & Platow, 2007), social work (Northern & Kurland, 2013) and occupational therapy (Cole, 2012; Finlay, 2004). The theory and practice of groupwork in mental health care settings has received research attention over the past few years (Waghorn, Lloyd, & Clune, 2009). Evidence-based therapeutic benefits of groupwork for persons with mental health concerns include stress reduction, increased ability to cope and improved general health and well-being (Babyak et al., 2000; Grossman, Niemann, Schmidt, & Walach, 2004).

Although occupational therapy has a well-established history in the use of groups as a method of intervention, there is little research-based literature regarding mental health occupational therapy and its related groupwork intervention methods in the South African context. There is also a limited scope of research on South African mental health service user’s views about occupational therapy groups. The perspectives of the clinicians regarding the use and value of a particular model or modality are often prioritized instead of service user views, with literature only focusing on MHCUs perspectives at the time of service (Lim, Morris, & Craik, 2007).

Groupwork is central to mental health occupational therapy services in South Africa. Although OTASA (2006) made a national call for assistance in constructing a position statement on groupwork in occupational therapy, it is unclear whether service users were consulted during the construction of the paper. Prior to its ratification, various persons voiced their concern regarding aspects of the position paper through letters to OTASA (personal communication with Louise Fouche from OTGrow & Helen Buchanan, 2016). Some of the concerns pertained to the lack of empirical evidence for basing the position statement almost entirely on the Integrative Groupwork Model

(IGM). One way of addressing these concerns is to research the views of the clients involved in the IGM as treatment modality.

The Interactive Groupwork Model (OT Grow, 2014) is promoted by OTGrow, an organisation which provides training and support for occupational therapists in mental health practice. Amongst other topics, OTGrow offers in-service training including experiential groupwork to therapists on the IGM. The IGM has a set structure including a warm up, rules, ice breakers, bridging, an activity and closure, with the activity being central to the model. Activity as a means is described as involving patients in significant ADL to improve their related capacities, in this instance it is using the activity to enhance or improve function (Gray, 1998). It is based on the humanistic frame of reference which argues that an empathic, non-judgmental stance by the therapist towards interactions between patients in a group will lead to therapeutic change (Yalom, 2005). There is not information in the literature on how the IGM is recognised by the South African health system, nor regarding how it is billed. No practice based evidence of the IGMs outcomes exist, therefore adding to the relevance of the current study.

To date, only a few South African occupational therapy studies have focussed on MHCUs' understanding and perceptions of occupation and what the implications thereof are for occupational therapy practice. These include the research of van Niekerk, 2004; Hajwani, 2008; and Gamielien, 2015. This study will be the first research into the perspectives of MHCUs on the contribution of the IGM to their recovery.

1.5 Striving toward recovery

Recovery has traditionally been conceptualised as the absence of disease, however in recent years there has been a significant shift towards understanding of recovery as a journey rather than an end point (Parker, 2014). Mental health recovery is described as a journey of healing and transformation enabling an individual with mental health concerns to live a meaningful life in a community of his or her choice while striving

to achieve his or her full potential (Mental Health America, 2015). Within the past decade, recovery-focussed intervention has been the trend in mental health care (Lim et al., 2007). This shift in focus from provider driven to consumer driven has implications for the provision of mental health services. In addition, service user feedback helps to confirm the quality and effectivity of occupational therapy provision.

Service-based definitions of recovery include recovery as the long term goal of remission (Andresen et al., 2005). Furthermore, it is viewed as a process of personal growth and development that involves overcoming the effects of being mentally ill with all its implications, to regain control and establish a personally fulfilling and meaningful life (Davidson, et al., 2005). A recovery orientation involves placing the needs of the patient at the forefront of treatment, and tailoring care plans to be personal and meaningful. Services in mental health care settings should have these core values at the heart of treatment.

User-based definitions of recovery include: overcoming the effects of being a patient in mental health care by retaining or resuming some degree of control in one's own life (Davidson et al., 2005) and, by establishing a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination (Andresen, Oades, & Caputi, 2003). As users are at the centre of recovery, it is important to ascertain their understanding and definitions of recovery. With recovery at the forefront of treatment in the current mental health service climate, it is imperative that occupational therapy links to recovery be investigated.

1.6 Research problem

To date, there is a paucity of literature documenting service user's perspectives on groupwork in occupational therapy within the South African mental health service context. In particular, there is no published South African research in occupational therapy regarding mental health service users' perspectives on the contribution of IGM

to their recovery. Unpublished informal documentation used for training purposes does exist, however it does not contain the perspectives of mental health service users.

1.7 Research purpose

In this study, practice-based evidence of service user perspectives on occupational therapy groupwork in a public sector mental health care setting was provided. In so doing, it may contribute to the refinement and validation of the IGM as an approach to occupational therapy groupwork in South Africa that is endorsed by an OTASA position statement. The information gained from the research will advance the inclusion of MHCU's views on intervention methods such as groupwork, thereby aligning occupational therapy practice with current policy directives regarding people-centred mental health care.

1.8 Research question

How do mental health care users perceive the contribution of the IGM to their recovery?

1.9 Research aim

To describe the perspectives of adult services users within a public sector mental health unit about the contribution of the IGM in occupational therapy groups to their mental health recovery.

1.10 Research objectives

- Describe the perspectives of MHCUs on the benefits of IGM for their recovery
- Describe the perspectives of MHCUs on the limitations of IGM for their recovery
- Describe the recommendations of service users on the refinement of the IGM

1.11 Summary

In this chapter it was argued that recent mental health policy developments call for the voices of service users to be considered in service delivery to ensure people-centred health care. The policy shifts in South Africa towards people-centred mental health care including the call for feedback from MHCUs on the impact of mental health care services on their recovery were clarified. An overview of the history of groupwork in South African occupational therapy illustrated the paucity of research on MHCUs' perspectives in the professional literature. The gap and the need for research in the particular area of groupwork in psychiatric occupational therapy was clarified. It pointed to the need for research that addresses the perspectives of MHCUs on the use of groupwork and the IGM in particular as an intervention method in mental health occupational therapy. In summary, the chapter outlined the research problem, purpose, question aims and objectives.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The review begins with an overview of key policies related to mental health with particular emphasis on people-centred care and the inclusion of user voice in policy and intervention design and concludes with an explanation of group-based programmes in specialist psychiatric units, with particular focus on their contribution to recovery. In this chapter, the history of groupwork and the perceptions of MHCUs regarding groupwork are also described. The Interactive Groupwork Model is described, highlighting its core concepts and structure of the group process. An extensive literature search yielded eleven research articles appropriate to the study³.

2.2 Key mental health policies and service user participation

Previously, service users' perceptions and opinions were not at the centre of policy and hence not at the core of treatment or service design. The health worker was seen as the provider of care and the client the passive recipient (Maitra & Erway, 2006). However, this has changed since the introduction of the HC2030 policy that guides

³ Databases:

- Ebsco (Academic Search Premier, Africa-Wide, CINAHL, Medline, PsychINFO)
- PubMed
- Scopus

EbscoHOST

- (occupation* therap* group*) AND (mental* ill* OR psych* ill* OR mental* health*) AND (patient* OR client OR mental health care user) AND (perceptions OR view*)
- Result(17)
- (occupation* therap* group*) AND (mental* ill* OR psych* ill* OR mental* health*) AND (patient* OR client OR patient OR mental health care user) AND (perceptions OR view*)
- Result(27)
- (occupation* therap* group*) AND (mental* ill* OR psych* ill* OR mental* health*) AND (therapist OR provider) AND (perceptions OR view*)
- Result (13)

PubMed

- (occupational therapy groups) AND(mental illness OR psychiatric illness OR mental health) AND (client OR mental health care user OR patient) AND (perceptions OR views)
- Results (41)
- (occupational therapy groups) AND(mental illness OR psychiatric illness OR mental health) AND (therapist OR provider) AND (perceptions OR views)
- Results (9)

11 Articles of the total number sourced were suitable (inclusion related directly to key words in the research question).

the vision and provision of health care in the Western Cape until 2030 (Western Cape Government Health, 2014). It emphasizes that the crux of the reimagined future for the Western Cape health service is a focus on patient centeredness. A crucial principle at the top of the Health Care 2030 vision list is patient centred quality care with “an individual dimension” (Western Cape Government Health, 2014 , p. 79). Placing individual patients at the centre of intervention is a value that is not foreign to occupational therapy (Mroz, Pitonyak, Fogelberg, & Leland, 2015). However, whether or not this value, referred to as client-centred practice, is upheld in occupational therapy standards of practice in South Africa is an issue which is yet to be explored. Client-centred practice in occupational therapy is defined as “collaborative approaches aimed at enabling occupation with clients who may be individuals, groups, agencies, governments, corporations or others” that requires “occupational therapists [who] demonstrate respect for clients, involve clients in decision-making, advocate with and for clients in meeting their needs, and otherwise recognize clients’ experience and knowledge” (Mroz et al., 2015, pg. 1). Client-centred practice has multiple benefits and positive outcomes including increased satisfaction with the results of occupational therapy, improved adherence to and compliance with treatment programmes, as well as decreased length of stay in rehabilitation facilities (Maitra & Erway, 2006). Thus, occupational therapy in the Western Cape should be well-aligned with the central positioning of the client in the regional health care policy.

Another policy foregrounding the issue of service user participation is the South African Mental Health Care Act 17 of 2002 which recognises that MHCUs are a vulnerable group. This act proposes and promotes the provision of mental health care services which would in turn promote the maximum mental well-being of users. Client-centeredness means that the perspectives of MHCUs are used to determine what mental health promoting services should entail. However, MHCUs have had few opportunities to participate in mental health reforms, revision of legislative policy and service development (Kleintjes et al., 2013). Although the process of developing the Mental Health Care Act, no. 17 of 2002 involved lengthy consultation with a range of stake holders, it occurred in the absence of formal peer-led structures in South Africa at the time (Kleintjes et al., 2013).

Peer-led mental health consumer structures take a long time to develop because people living with psychosocial disability are widely stigmatized, with mental health advocacy often given low priority (Bird et al., 2011). When people living with psychosocial disability are given the opportunity to be included in regulatory provision for mental health services including socioeconomic upliftment, they become empowered to influence policy and in so doing, influence their own mental health (Kleintjes et al., 2013). The terms mental illness and psychosocial disability are often used interchangeably in the literature (Harvey et al., 2016; Kleintjes et al., 2013). Episodes of mental ill health are reduced by prioritising consumer participation in policies affecting mental health services and by including MHCUs in the social, economic and political life of communities (Funk, Van Ommeren, Mental Health and Poverty Project, & World Health Organization, 2010). Groupwork is a commonly used modality of intervention in the mental health sector, and more importantly, is a commonly used practice in the profession of occupational therapy. In order to understand its contribution to both mental health interventions and the profession of occupational therapy, the origins of occupational therapy groupwork and how it is used, were explored.

2.3 Group therapy in mental health

Groupwork is often used as a primary therapeutic modality in mental health settings (Pollard & Cook, 2012). Therefore, it would be important to review the empirical data of the impact of groupwork in mental health and recovery.

Koukourikos and Pasmazi (2014) explored the efficacy of group treatment with inpatients with psychosis, and found that inpatient group therapy is effective when included as part of an holistic program. Group therapy which is empathy orientated did not always lead to positive results for institutionalized patients. However, group therapy which is interaction orientated assisted in improving the social and interpersonal conduct of patients. Groups that focused on social skills training was found to be effective for day patients. Similarly, in a study exploring the effectiveness of inpatient group therapy with comorbid complicated grief, it was found that group

therapy had a significant impact when treating and reducing grief symptoms (Rosner, Lumbeck, & Geissner, 2011).

In a study exploring the efficacy of cognitive behavioral therapy groups in clients with depression, results indicated that groups were an effective modality in reducing the symptoms of depression and participants remained stable for a longer period. Given the nature of depression the study reported a high dropout rate and indicated that this may have had an impact on the depth of the results (Thimm & Antonsen, 2014).

In a clinical review of psychotherapy and group analytic therapy by Blackmore, Wong, & Johnson, (2009) the use of group analytic psychotherapy as an approach was supported and was found to be efficient. The use of these groups was supported across diverse conditions, participant groups and settings. Thus, groupwork as a modality is an appropriate and effective modality in mental health and recovery. It is therefore important that the use of groupwork in occupational therapy is explored.

2.4 The history of groupwork in occupational therapy

Historically, groups have been used as a central method of intervention within mental health occupational therapy. The evolution of occupational therapy groupwork is described in the work of Howe & Schwartzberg (2001). The Project Era (1922-1936) involved the use of groups as a collective where the group did not always have a goal or an independent task. Thereafter, during the Socialization Era (1937-1953), occupational therapy groupwork allowed patients an outlet for social needs as well as a vehicle for experiencing social gratification from positive social contact. The Group Dynamics-Process era (1954-1961) followed where a shift in occupational therapy treatment was seen. Professionals recognised the curative powers of groups and sought to use these powers in reaching treatment outcomes. In the Functional Era (1970-1990's), groups had a clear functional aim with a sound theoretical rationale. Socialisation, communication were goals, as well as the use of activity to increase physical, cognitive, social and task skills.

Even as the form of occupational therapy groups changed through the years, professionals remain convinced of groups as an effective treatment modality.

Engaging in a group setting provides a natural learning environment with multiple opportunities for interaction (Cole, 2014). The MHCUs attending groups in mental health care settings often share similar problems, and therefore similar therapeutic aims related to occupational performance. Cole (2014) suggests that the aims of occupational therapy groups are often to create the space to engage in discussions related to occupations of daily life, social interaction and one's concept of the self. The contribution of these discussion topics to recovery has been alluded to by a range of mental health disciplines including social work (Carpenter, 2002), psychology (Slade, 2010) and nursing (Barker, 2001).

2.5 Types of occupational therapy groups

Many types of treatment groups are used in different settings, however, all can be described under four main categories: activity groups, intrapsychic groups, social systems groups and growth groups (Cole, 2012; Finlay, 2004; Howe & Schwartzberg, 2001). These groups can overlap and be combined.

Activity groups are small and group members are commonly engaged in a shared task or activity that is directed towards learning and maintaining occupational performance (Cole, 2012). The intent of the group is to provide a shared working experience wherein the relationship between feeling, thinking and behaviour, their impact on others, task completion and productivity can be seen and explored. Thus, the task-orientated group creates an excellent learning environment. Task completion is not the core purpose of the group but rather the means through which the purpose is realised. Alternate patterns of functioning can be considered and tested within the here-and-now, and as a result, this may induce ego growth and improve function (Cole, 2012). The activity is seen as a catalyst in eliciting behaviour, interaction, brings into focus both functional capacities and limitations, facilitates collaboration in working through difficulties, and provides a concrete factor against which learning and achievement can be measured (Cole, 2012). Tasks in relation to occupational therapy activity groups are defined as any process directed toward creating or producing an end product or demonstrable service for the group as a whole or for others. Some examples

of tasks commonly selected for groups are cooking, gardening, ward decoration and improvement (Cole, 2012).

The use of activity groups has roots in two different theoretical constructs. The first being the principle of group dynamics and how curative factors within the group bring about positive behavioural change. The second being the importance of “doing” and therefore the role of purposeful activity in maintaining and developing skills. Activity is used as means, rather than as end. The facilitator adds to creating a group climate that facilitates interaction, provides support for members as well as relates group processes to the concerns of its members. The facilitator selects and structures appropriate activities at the level of the group, as well as acting like a role model guiding the learning of interpersonal and task skills. Wilcock (1999) described “doing as providing a mechanism for social interaction and societal development of growth, forming the foundation stone of community, local as well as national identity. It is the doing that shapes and creates societies that we live for. She suggested that “doing” is a concept so important that it is almost impossible to imagine humans without it (Wilcock, 1999).

Mosey (1981) suggests six major types of activity groups: evaluation groups, task-orientated groups, developmental groups, thematic groups, topical groups and instrumental groups. Again, these types of activity groups are not discreet, and some may have properties of several categories.

Intrapsychic occupational therapy groups aim to achieve characterological and personality changes in group members by ‘working through’ the personal intrapsychic and historical antecedents of the present maladaptive and dysfunctional personality patterns that occur in the group members (Howe & Schwartzberg, 2001). These groups are primarily focussed on psychoanalytic theory with its core principles being applied to the group. The focus of observation and analysis is mainly placed on the individual group member, and not on the group as a whole. Within these groups, the facilitator guides the members in their exploration, interpretation and ‘working through’ personal conflicts. The facilitator validates and clarifies members’ perception of reality. Projective mediums such as art, clay, paint and music are often used in these groups

to encourage participation. However, the group is reliant on the facilitator to interpret their behaviour (Cole, 2012).

In social systems groups, the general aim is to assist group members in learning about group processes and dynamics through participation in a collective task experience (Howe & Schwartzberg, 2001). Attention is directed towards how relationships are formed and stabilized within the group, how decisions are made, how patterns of behaviour emerge, and how the parts fit together to form a group, team or family. Social systems groups are based on the application of systems theory to the concepts of group processes and dynamics (Sampson & Marthas, 1981). The focus is on the here-and-now activity of the group and the interaction with its environment at the present time. The role of the facilitator in these groups is to participate in the group as a member-expert and to establish an environment appropriate for process analysis. The facilitator aims to focus the group on 'how' instead of 'why' or on the here-and-now events. The group's reliance on the facilitator is situational and transient.

The aim of growth groups are to increase group members' sensitivity to feelings as well as enhancing members' ability to assist themselves using the power of the group (Howe & Schwartzberg, 2001). Growth groups focus on personal growth through didactic and action-orientated experience. These groups are based on the principles of humanistic and existential psychology that aim to fulfil the potential inherent in individuals. The role of the facilitator in these groups is to facilitate learning, interaction and experience among group members by modelling openness, spontaneity, expression of feelings and mutual aid. The group members are reliant on the facilitator only as a teacher or contributor to the group.

2.6 The complexities of occupational therapy groupwork practice in the current health care service

Groupwork is a cost effective treatment modality in healthcare (Drum et al., 2011). Groupwork is a well-known and regularly used modality in mental health practice

(Cole, 2014; Finlay, 2004; Howe & Schwartzberg, 2001). However, the mental health budget allocation is markedly insufficient to meet the needs of the growing mentally ill population (Bird et al., 2011). The health of individuals and communities is a delicate social construct, it is unlikely to improve with increased spending on medical expenses (Benatar, 2013). The budget for health is not enough to improve and sustain health for all. Thus, it is of great importance that an appropriate and effective occupational therapy service be provided in this already budget-limited space.

The aim of occupational therapy in mental health is to assist service users to develop the skills and acquire the supports necessary for independent and productive living (Arbesman & Logsdon, 2011). Bearing this in mind, using client-centred and occupation-based assessments, occupational therapists develop intervention plans constructed on the clients' goals and choices (Arbesman & Logsdon, 2011). Though this type of intervention is 'client-centred', it begins with the occupational therapist assessing the client's needs, and treatment planning with the client follows thereafter. Instead, the view of the client should be taken into account at the start of treatment. Recovery is a personal journey and should be the focus of intervention from the onset of the collaboration between the MHCU and the occupational therapist.

Group intervention is a widely recognised method of treatment in mental health settings, yet there is a scarcity of research that focuses on the service users' experiences of group sessions (Caruso et al., 2013). Though the current research is not focussed on the experiences of service users but rather on their perceptions of a particular treatment approach, the paucity of research on the topic remains a concern. With the vast needs of MHCUs admitted to psychiatric units, clinicians face challenges in developing groupwork programmes that are relevant and meet the complex needs of the population.

Groups can be designed to address various needs and goals. The range of occupational therapy groups described earlier exists to suit the therapeutic, developmental and educational needs of individuals and communities. Given the direction of policy towards consumers being involved in service design, it would be important to obtain the perceptions of MHCUs on groupwork.

2.7 MHCU's perceptions on groupwork

Research into service users' perception of occupational therapy groups in acute mental health settings is limited (Lim et al., 2007). Research on occupational therapy groups in mental health care have focussed on client-centred practice. Occupational therapy theory suggests that client-centred practice is a vital aspect as it is concerned with the aspect of "realigning power" (Townsend, Stanton, Law, Polatajko, & Baptiste, 2002). A dated yet relevant definition of client-centred practice by Law (1995) states that it is "an approach to providing occupational therapy which embraces a partnership with people receiving services. Client-centred practice recognises the autonomy of individuals, the need for client choice in making decisions about occupational needs, the strengths clients bring to a therapy encounter, the benefits of client-therapist partnership and the need to ensure that services are accessible and fit the context in which the client lives" (p. 253). Client-centred practice offers patients choice and meaning in the activities and guidance in expressing their personal perspectives on their needs (Rebeiro, 2000). However, it would also seem that occupational therapists do not always realise the inequities of the power that they wield as this would have an effect on the power dynamics between the therapist and the client (Whalley Hammell, 2013, 2015).

Recent studies of patient's perceptions have shown the therapeutic factor most valued by mental health care users in occupational therapy groups is the sense of being accepted by others in a group, gaining success, interacting with others and hope (Eklund & Bäckström, 2006). In this study it was also found that both patients and therapist highly valued group cohesiveness, instillation of hope, and interpersonal learning (Eklund & Bäckström, 2006). These findings suggest that a client-centred group would allow for improved perceptions on the contributions of the groupwork process to healing. Cowls and Hale (2005) suggest that current trends in mental health facilities are towards reduced hospital admission, coupled with increased insight by the client of their illness. Trends such as these force occupational therapists to continually examine their therapeutic programmes to be certain that they are meeting their client's needs, so that hospital admissions are either reduced or avoided. Though research by Cowls and Hale (2005) was not conducted in South Africa, the essential

professional duty in meeting the needs of the clients served by occupational therapists, remains irrespective of where they practice.

Relevant therapeutic services are tailored when the needs and perspectives of the clients, from the clients themselves, are taken into account. Fearing and Clarke (2000) put forward that as the profession of occupational therapy claims to reflect a client-centred perspective, intervention such as groups should meet the needs of the clients and not be solely reflective of therapist preference and or the therapist's perceived needs for the clients. Miatra and Erway (2006) reported that even though occupational therapists perceive themselves as using a client centred-approach, the clients receiving the treatment did not consistently report feeling like an active participant in their treatment and were unaware of the client-centred approach being used by the therapist. A focus on recovery means that occupational therapy groups must also address the ongoing post-discharge needs of MHCUs. Geppert and Abbot (2007) report that although there has been an increase in the inclusion of the concepts of self-determination in the medical community, it is the psychiatric community that has lagged behind in recognising clients' rights to give input in treatment planning and decision making.

Literature regarding mental health care user's perspectives on the role of the IGM in occupational therapy groups could not be found. This leaves a gap in the literature and creates a space for research to be conducted concerning the perspectives of the client regarding the role of the IGM in recovery. The IGM model is an indigenous model created in South Africa, and therefore research done regarding this model will be relevant within the South African occupational therapy context.

2.8 Occupation as means

According to Trombly, (1995) occupation as means refers to an occupation acting as the therapeutic medium to remediate and address impaired abilities or capacities. Here, occupations were described as "limited simple behaviours" (p. 4) and provided examples of purposeful, repetitive activity designed to enhance a particular motor

performance components. Gray, (1998) however, asserts that the above simple behaviours are precursors to occupation and not occupation themselves. Gray, (1998) proposes that occupation as means refers to the use of therapeutic occupation as the treatment modality to assist individuals in advancing towards an occupational outcome. Using occupation as a treatment modality cannot be used unless a thorough occupational history is obtained. Gray, (1998) further asserts that when occupation is used as means it can provide a unique contribution to a client's recovery.

Occupational therapy as a profession has been historically based on the notion that occupation is vital for basic well-being (Ikiugu, Hoyme, Mueller, & Reinke, 2015). 'Doing', as theorized by Wilcock, (1999), is of utmost importance to remaining well. 'Doing' or 'not doing' are powerful determinants of wellbeing or disease. It is therefore not surprising that occupation as means is often at the centre of occupational therapy practice in mental health care settings. Meaningful occupation is the core construct underlying the practice of occupational therapy (Ikiugu et al., 2015). Even though occupational therapy is based on the notion that meaningful occupations (used as means) are related to health and a sense of well-being, the precise nature of these types of occupations is not always well understood. With this in mind, it would be important to explore the link between occupational therapy and recovery from mental illness.

2.9 Occupational therapy and recovery

Current understanding of recovery from mental illness is that the process towards improved mental health and well-being is more like a journey rather than the arrival at an endpoint or outcome. This journey begins with the acceptance and recognition of a mental health issue and the aspiration to begin the journey of healing (Parker, 2014).

Jacobson and Greenley (2001) describe four internal conditions that need to be present for recovery to take place. These conditions are firstly, that hope that recovery is possible creates a frame of mind that allows the healing process to occur. Secondly,

understanding that healing is fundamentally different to cure, with a strong emphasis on the self as opposed to the illness and control of symptoms and dysfunction. Thirdly, empowerment as an aid in the correction of hopelessness and dependency that arises with severe mental illness and fourthly, connection with society and knowledge and understanding of their roles in it (Jacobson and Greenley, 2001). More needs to be known about the contribution of occupational therapy groupwork and the IGM in particular to the development of these internal conditions for recovery.

To ensure that a programme is recovery focussed, specific elements need to underpin the practice. The first element is person orientation, which means viewing the mentally ill person holistically (Farkas, 2007). Second is person involvement, which means that consumers living with mental illness are valued by directly including them in the design, planning and delivery of services (Farkas, 2007). The third element is self-determination, which is the understanding that consumers need to establish the meaning of ‘better’ for themselves, determine their own goals, establish their own plans to achieve these goals, and take responsibility for the outcomes of these decisions (Farkas, 2007). Lastly, the value of hope is required, which involves the ability to discern the effects of when services are provided in a negative environment, and the deep healing benefits of a positive atmosphere (Farkas, 2007). Taking these values into consideration means that recovery-orientated practice involves individuals as the focus of intervention by facilitating choice, opportunity and holding and promoting hope for each person’s future. The journey of recovery is driven by the individual in line with their choices, goals, and rights. A recovery focus requires movement away from the medically-orientated care whereby the absence of symptoms is the primary outcome focus. Instead, a recovery-orientated focus endeavours to enable individuals to reclaim and develop new meaning in their lives (Nugent, Hancock, & Honey, 2017). It is therefore helpful for occupational therapists to know more about the ways in which the IGM contributes towards MHCUs recovery journey.

With this recovery-orientated approach in mind, occupational therapy is ideally positioned to facilitate recovery-orientated practice due to the congruence between occupational therapy theory of client-centred practice (Nugent et al., 2017) and recovery orientated principles including internal conditions (Jacobson and Greenley, 2001) and values (Farkas, 2007). Principles such as autonomy, choice, strong

therapeutic partnerships and enablement are central constituents of both occupational therapy and a recovery approach (Nugent et al., 2017). The ways in which occupational therapists go about developing and sustaining a recovery-based focus in mental health practice was explored by Nugent et al. (2017). Both consumers and occupational therapists were involved in this particular study. A number of parallels were drawn between the therapists' journey of developing and sustaining a recovery-orientated practice and the recovery journey as described by the consumers. Enablement was a central constituent of both occupational therapy and a recovery approach (Nugent et al., 2017). Recovery cannot be achieved without engagement in occupation, and the journey of recovery cannot be walked without participation in occupation being enabled. The interface between recovery and occupational therapy is based on the assumption that occupation is a basic need for continued existence, quality of life and identity formation (Wilcock, 2006).

A study conducted by Kelly, et al., (2010) highlighted the vital link between occupation, recovery and mental health. Participants were involved in group and individual activities as part of a Non-Governmental Organisation (NGO) programme. The findings emphasized the importance of occupation in relation to active participation in life, barriers to occupation and making strides towards mental health recovery. The participants in the particular study described recovery as an occupational journey involving responsibility, active choice, empowerment, hope and meaning. Engaging in occupation was vital in the participants' recovery journey. The key factors found to influence recovery were the participant's knowledge of recovery, re-establishing a self-concept in a safe and supported environment, possible barriers to occupation and the overarching necessity for engagement in occupation to promote and maintain mental health.

The future of recovery-orientated practice is vital for the development of mental health services in resource limited South Africa. The movement towards recovery requires various stakeholders and role players including the consumers, their families, state services, communities and NGOs to collaborate in operationalising the internal conditions, values and principles of recovery (Parker, 2014). Knowing more about the contribution of the IGM towards recovery-orientated services is therefore an important research initiative.

2.10 The Interactive Groupwork Model (IGM)

There is no published literature on the IGM. The information regarding IGM is passed down through in-service and course-based training, mainly via lectures to occupational therapy students or courses run for clinicians by members of OTGrow. The information presented in this literature review is based on course work notes issued by OTGrow and used with the permission of Louise Fouche, the founder of the interest group. Telephonic contact, and email communication with Dr. de Beer, and Louise Fouche, primary originators of the IGM were the main forms of information gathering on the history of the IGM.

The IGM was created in the 1980s by de Beer, an occupational therapist and Voster, a clinical psychologist from the University of Pretoria. The model is grounded in Yalom's (1975) curative factors of groups. However, it has been adapted in order to remain within the occupational therapy scope of practice, which requires the use of activity as primary means of intervention. The focus on activity differs from Yalom's approach to groupwork, which is a closed, supportive and talking only space (no activity). The IGM was created by de Beer and Voster in response to challenges de Beer was having in relation to teaching groupwork theory in the undergraduate occupational therapy curriculum at the University of Pretoria. De Beer believed that the groupwork course was incomplete because it lacked a profession specific model for groupwork. Groupwork is a core competence required when occupational therapy graduates enter the working world. She spent a considerable amount of time observing occupational therapists in action in an effort to explore the essential features of occupational therapy groupwork. After observation of several therapists in South Africa she began to notice that therapists seemed to ask questions at the right time instinctively in relation to group member's activity participation. De Beer understood that instinct could not be taught and that she needed to train students who were not yet skilled in groupwork to discern critical points during the life of a group when questions were necessary in order to help its members achieve therapeutic outcomes. De Beer met with a psychologist, Voster, from the Medical University of South Africa (MEDUNSA), and together they developed the Interactive Groupwork Model specifically for occupational therapists.

2.10.1 Core concepts of the Interactive Groupwork Model

The following core concepts about groups underpin the IGM:

- A core belief of the interactive approach is that mental illness is rooted in poor social relationships whereby negative interactions, family discord, withdrawal and isolation are common factors. Bearing this in mind, groups are used to provide particular interactive experiences effectively to change social relationships. The term ‘interactive’ implies action in an engaging manner. Interaction is defined as “to have an effect on one another” (OT Grow, 2014, p. 6). Therefore the IGM authors argue that all action with others is interactive and that all interactions have an effect on one another.
- Groups as part of a social microcosm and can be seen as a mini slice of society. Therefore, the behaviours engaged in outside of the group setting are believed to be reflected within the group setting. MHCUs that are exposed to the IGM are believed to reflect a mini society.
- Direct communication is essential to the success of the IGM. Talking directly to the person involved is what creates the greatest impact.
- Here and now - This concept refers to the notion that the past cannot be changed, and the future is yet to come, and therefore the focus of the IGM is the ‘here and now’. The focus is on what is happening in the present. What is happening in a group is triggered by the use of an activity to focus attention on particular actions and reactions.
- Leading from behind - this concept is to emphasise that the group therapist is the facilitator and not a leader in the group process. The group progresses at its own pace, and is not forced in any direction. However, the occupational therapist is skilled in asking critical questions as critical points during the group interactions to facilitate critical learning as indicated by the emerging needs of the group.

2.10.2 The IGM group procedure

There are various ways in which to proceed with an IGM group (OT Grow, 2014). The IGM procedure may include:

- **Introduction**

The introduction is only necessary for the initial group session because members get to know one another as patients within a particular therapeutic setting. New members are introduced when they are admitted and deemed suitable for occupational therapy groups. The introduction stage involves an introduction to who the therapist is, who the members are, as well as a brief explanation of the group procedure, process and purpose.

- **Norms**

Following the introduction stage, the group members need to establish norms and rules for the duration of the group session.

- **Meeting the group at their emotional level**

The therapist then moves on to how the group is feeling. Meeting the group at their emotional level has various functions and benefits, such as verbalising the emotions the members of the group are currently experiencing, and being able to recognise others' emotions, which encourages acceptable expression of emotions and awareness of others.

The reasons for a focus on feelings are as follows:

- i) It gives the therapist an idea of what emotional level the group is functioning on at a particular point in time and what can realistically be expected from group members.
- ii) Understanding the emotional level of individual members and the group as a whole enables the therapists to meet them at that level.
- iii) It allows the group members to 'download' issues or conflict that they bring from outside into the group. It also allows members the opportunity to express their feelings and create a mental space for the group.

iv) From an individual point of view, it enables the therapist to monitor progress with regards to the client's mood and affect including how it impacts on their occupational performance as social being while being a group member.

- Warm up or ice breaker

A warm up, also called ice breaker, involves a short activity prior to the main activity and is defined as getting to know you activities and designed to break down barriers before starting an event (Chlup & Collins, 2010). Ice breakers as part of the IGM are required to meet the following criteria: Facilitate group cohesion, facilitate interaction, decrease anxiety, increase spontaneity, and introduce the theme of the group. Ice breakers are used to warm up a group for interaction. Examples of ice breakers include: Social Bingo where members have to ask others a series of questions to discover similarities and differences between themselves and the group and Two Truths and a Lie where members share two truths and one lie, and other members try to discern which are truths and which are lies.

- Bridging

Bridging refers to the stage between the warm up and the main activity. General questions and problem spotting, or signing a group contract, are used at this stage. It belongs to the group members with the therapist merely facilitating a process. It is vital that the therapist remains open to the group's response, for example, feelings around unfairness need to be discussed, and members are encouraged to share their views by giving and receiving direct feedback to each other. This requirement proves that the group belongs to the group members and that they take responsibility for the group as well as the consequences of their decisions. The therapist is present to ensure a fair process of negotiation.

- Activity

The main activity is a means to an end. It is chosen to fit the theme of the group. The theme of the group is identified by the OT after understanding the needs of the group via assessment during the ward programme and discussions with the rest of the treatment team. Activities are analysed and selected that elicit varied

amounts of anxiety or that have the potential to build self-esteem or promote self-awareness. Examples of activities include:

Jenga. This game involves removing rectangular blocks from a stacked tower. Destabilising the tower raises anxiety in group members, until ultimately the tower collapses.

Fashion show. This activity involves group members planning a fashion show and executing the planned activity. Group members can use their own clothing or use some of the clothing provided. The activity requires the ability to plan an activity with others, as well as manage anxiety during the show when performing for others.

Creating gifts with personalised messages. This activity involves group members drawing one another's names randomly, decorating a provided box and adding a personalised positive message to the individual. These gifts are given to one another in the group and messages read for all. It is selected when the group needs to work on self-esteem and building self-awareness.

- Feedback and norm setting

Many activities function on the basis that the group members are given time to draw or make something and once everyone has completed the activity, the group members are expected to explain their drawing or end products. However, this is not the case with the IGM. It is important for the therapist to start the sharing and feedback in the group and to participate throughout the process for two particular reasons. The first reason is that the therapist acts as a role model through his or her participation. Role modelling is named 'norm setting' in the IGM. The group members will follow the example and level of sharing set by the therapist. The second reason is that by participating as an equal group member, the group members are confronted with the myth that therapists have no problems and are better than the group. Participation involves sharing to facilitate trust between the therapist and the group members. When the therapist begins the process of sharing, group members are able to see what appropriate behaviour within the group looks like. In addition, this principle encourages group members to participate in the

group process without reserve and facilitates instilling hope as a curative factor, as identified by Yalom (1975).

- Post activity discussion

It is during this discussion that the most interaction happens, and feedback is given on particular events and occurrences in the group, based on observation.

If the activity requires it, an explanation of the end product is given by all group members. At this stage, the group may have moved to other more relevant issues in the group. The therapist follows the group process, facilitating curative factors by asking appropriate questions as the opportunity arises, for example, pointing out similarities to foster universality.

To begin the post-activity discussion, the group is asked to describe their experience of the activity. It is imperative that open-ended questions are asked in order to elicit talking and interaction. The ‘here-and-now’ process of illumination helps group members to reflect more deeply. Reference to the ‘here-and-now’ encourages group members to address feelings and thoughts in the moment honestly. Members are encouraged to address conflict and feelings of unease in the moment as they are occurring (Lieberman & Trope, 2008).

The therapist is encouraged to be aware of the energy levels of the group when sharing and feedback occurs. If conflict arises, it would not be therapeutic to end the group without resolving it. The therapist does not give the group an option to end, as the group may try to avoid the conflict and opt to sort it out at a later stage. Dealing with conflict in the ‘here-and-now’ is most effective and brings healing, while leaving conflict to later will increase anxiety and decrease the group cohesion. The therapist focusses the group and helps them to become aware and identify the conflict and work through it by facilitating appropriate communication and conflict resolution within the group space.

It is imperative that enough time is available for the post-activity discussion. If there are not many issues that have been raised, the therapist can end the group earlier. Alternatively, the therapist can suggest that it seems that the issues have

been concluded and allow the group to start a new discussion should they wish to. The group should not be forced to fill up scheduled time if the group process is completed, as this may be detrimental to the natural group process that has unfolded. In addition, protracting a group conflicts with one of the key elements of the model, namely, leading from behind where the therapist allows the group to lead their own process.

- Closure

Once the discussion is completed the group can be closed. The therapist provides the opportunity for anchoring core themes which the group members would like to take forward to generalise in the outside world. This stage offers an opportunity for the group to have a definite end, with regards to a particular group experience. It allows the therapist to evaluate the group by paying close attention to what was effective for the group members and what may not have had the necessary impact that had been hoped for.

2.11 Summary

In this chapter, pertinent articles and documents pertaining to occupational therapy groupwork in mental health, recovery, and MHCUs perceptions' of groupwork were reviewed. It illustrated that the benefits and limitations of groupwork as a treatment modality, highlighted the role and similarities of occupational therapy and recovery orientated practice and outlined the IGM model describing its procedures and beliefs. It argued for research to be conducted in obtaining a consumer perspective on the IGM and its contribution to recovery for MHCUs.

CHAPTER 3: RESEARCH DESIGN

3.1 Introduction

In this chapter, the theoretical underpinnings and methodology employed in the study were described. In alignment with the beliefs of qualitative descriptive design, the study respects the multiple realities from which the data emerged (Creswell, 2007). The discussion included descriptions of the research methods utilized, the processes followed in generating, managing, analysing and interpreting the data and the steps taken to ensure ethical research practice with vulnerable participants. The chapter was written in the first person as the researcher was the only data collector in the research process.

3.2 Methodology

The study methodology was guided by a descriptive qualitative design positioned in a social constructivist paradigm (Creswell, 2007). Qualitative research design was indicated because the aim of the study was to describe rather than quantify perceptions of MHCUs of a particular treatment modality used in mental health occupational therapy. Social constructivism was operationalised by giving MHCUs the opportunity to share their views on group therapy sessions run according to the IGM and its contribution (or not) to their recovery.

3.3 Philosophical standpoint

The study was guided by the principles of social constructionism which enabled the researcher to develop an understanding of the subjective meanings that research participants held towards certain events, objects or things which in this instance, were their perspectives on groups using the IGM (Gergen, 2009). I considered social

constructivism to be a suitable philosophical framework for answering the research question because it considers knowledge as constructed through individual perception and social understanding. The occupational therapy groups that the MHCUs were involved in were seen as a social microcosm within the context of a specialist psychiatric unit. The ward-based group microcosm is representative of the groups they are part of in the greater society that they live in. One of the beliefs of the IGM is that learning, and by inference behaviour change towards improved mental health and well-being, is constructed within groups that follow IGM guidelines (de Beer & Vorster, 1980). In the research, I set out to uncover whether this assumption of the IGM was supported by the experiences and perspectives of MHCUs. The perspectives of MHCUs about the IGM and its role in their recovery were multi-layered, value-laden and socially constructed. Based on social constructionism, I acknowledged complexity in the way MHCUs constructed their views on the IGM and its links to recovery. Acknowledging complexity stands in contrast to narrow meaning making such as trying to establish a causal relationship between the IGM and recovery. In keeping with the paradigm of social constructionism, the goal of the research was to rely on the participant's views of the occupational therapy situations in which the IGM unfolds. One of the core beliefs of the IGM is meaning-making in relation to personal recovery from a mental illness. Meaning is developed through interactions that unfold during occupational therapy groups, hinting at the value of social constructionism as philosophical standpoint in this study. Social constructivists address the 'process' of interaction among individuals with a focus on the contexts from which the individuals come. In this instance, the implications of the IGM on their recovery was in the contexts of their lives. Social constructionism also required that I recognised my personal and professional background and its influence on how it shaped my interpretation of the patterns of meaning that emerged from the data (Creswell, 2007).

3.4 Researcher positionality and assumptions

I am a young woman from Cape Town. I was brought up in a middle-class family and would consider myself to be socially and economically privileged. My work experience as well as my passion has been mental health. My choice to conduct

qualitative research was based on my belief that there are multiple related realities connected to the perceptions I hold of a particular occupational therapy model of practice (Creswell, 2007). In the next section, I share some of my assumptions in relation to the study question.

3.4.1 Ontological assumptions

The world is a social world and is populated with many human beings who derive their own thoughts, interpretation and meaning (Burr, 2015). I therefore assumed that each participant would have their own personal and different view with regards to the IGM and recovery. Meaning is not discovered but constructed (Burr, 2015). I therefore assumed that the participants would have constructed their own individual meaning related to the IGM. The construction of meaning is a process, and therefore may change over time, hence the importance of obtaining longitudinal perspectives on what exposure to the IGM may contribute (or not) to the journey of recovery including in-patient perspectives and post-discharge retrospective perceptions.

3.4.2 Epistemological assumptions

In agreement with Law (1996), I believed that ill health affects the dynamic interaction between person, environment and activity. I therefore supported the assumptions held by De Beer & Voster (1980) about the power of activity to guide therapy and lead the journey to recovery.

3.4.3 Methodological assumptions

In agreement with Clark & Fearing, (2000) I believed that the participants would have a sincere interest in participating in the research and would therefore respond in a honest and authentic manner during the interviews.

3.5 Research context

It is not possible to separate context from what people say (Creswell, 2007). Attempting to gain an understanding of the perspectives of MHCUs on the role of the IGM in occupational therapy groups was particularly complex as will become clear in the description of the study context.

Unit X is a tertiary care, adult in-patient, psychotherapeutic unit of a regional hospital in South Africa that offers a consultation liaison psychiatric service. Users admitted to the unit have a primary Axis I or II diagnosis with an Axis III (medical co-morbidity) diagnosis that impacts on their ability to manage their mental illness. Axes, as per the DSM-IV, refer to categories of information related to an individual's diagnoses, psychosocial stressors, as well as level of functional impairment (American Psychiatric Association., 1994). The multi-axial categories of information have been done away with in the DSM V (American Psychiatric Association., 2013). Though the use of the DSM-IV has been done away with, there are facilities including Unit X that still use the criteria to inform admissions to the unit. The unit admits adults requiring complex care, most frequently those with eating disorders, personality disorders, somatoform disorders, adjustment disorders, anxiety disorders, mood disorders, conversion disorders including gynaecological related mental health problems and chronic psychogenic pain. The unit does not admit persons with psychotic disorders.

Unit X was selected as the study site because:

- It is a contained treatment environment in which individuals remain for several weeks enabling study participants to have had sufficient exposure to occupational therapy groups based on the IGM, to be able to make an informed opinion about its impact (or not) on their recovery.
- It offers a holistic occupational therapy service that includes groups run using the IGM as practice approach. The occupational therapist on Unit X is trained and experienced in the application of the IGM.

Unit X is a 12-bed unit where MHCUs participate in an 8-12-week therapeutic programme offered by a multi-professional mental health team. New MHCUs are

admitted every 4 weeks. Groups are run by different professionals using a range of frames of reference including cognitive behavioural therapy (Butler, Chapman, Forman, & Beck, 2006) and psychodynamic therapy (Rutan, Stone, & Shay, 2014). The average group size in Unit X is 6-8 MHCUs. The occupational therapist runs 2 groups per week of approximately 2-hour duration, both using the IGM as the practice approach (See Appendix B).

3.6 Population and sampling

The study population was all patients admitted to Unit X who received groupwork interventions, including IGM, during the time of the study. A maximum of 12 MHCUs are admitted in the unit at one given time. Creswell (2007) suggests that purposive sampling in qualitative research design provides an optimal opportunity to illustrate different perspectives regarding the same problem. Purposive sampling occurred by demarcating the study period and applying inclusion and exclusion criteria to admissions during that time (January- July 2017).

Purposive sampling was also used to identify individuals who could be considered 'experts' with regard to the phenomena of interest (Morse, Barrett, Mayan, Olson, & Spiers, 2002), for instance, persons who had longitudinal exposure to the IGM and who could reflexively describe its benefits (or not) for recovery. MHCUs with different rates of exposure to groupwork and IGM in particular were considered in terms of first-time admissions vs. those who have had multiple admissions and therefore repeated exposure to IGM. Inclusion and exclusion criteria were applied to each new person admitted to the ward to ensure maximum variation in age, gender, diagnosis and number of admissions where exposure to the IGM had occurred before. Consideration was given to the number of opportunities to apply therapeutic benefits of exposure to IGM groups during community re-integration, when the process of recovery is most likely to be operationalised. The reason for using both purposive and maximum variation sampling was to ensure maximum variance of perceptions of recovery related to groups based on the IGM among informants.

3.6.1 Selection and recruitment of participants

MHCUs who met the inclusion criteria were invited to participate in three interviews. Recruitment took place during January 2017 to July 2017 until the desired number of six participants was reached, allowing for one drop out during the process. A sample size of five participants was considered sufficient because meaningful saturation of information answering the study question can occur with even one case (Boddy, 2016). During the recruitment process seven female participants were included, as an attempt to ensure saturation. There were no male MHCUs who were found to fit the inclusion criteria during the recruitment period. Potential participants would have gone through one week of the programme, with at least one exposure to the IGM to enable them to make informed decisions about whether they wish to participate in commenting on the IGM approach to their recovery.

3.6.2 Inclusion criteria

Table 3-1 Table depicting the inclusion criteria

Gender	Males and females were eligible. Reason: Gender may introduce particular ways of engaging with the IGM and applying its therapeutic intentions to recovery
Age	A spread of age between 18-65 years. Reason: There are various factors during different stages of life that may have introduced particular ways of engaging with the IGM and applying its therapeutic intentions to recovery
Diagnosis	A spread of diagnosis aligned with screening admission criteria for Unit X. Reason: Diagnosis may introduce particular challenges to recovery that the IGM may (may not) be able to address
Admission	Number of admissions to Unit X. Index admission to Unit X; multiple admissions to Unit X. Reason: multiple admissions suggests multiple exposures to IGM & therefore the possibility of having information rich perspectives on longitudinal benefits of IGM
Language	All languages will be included as long as the participant is able to converse & participate in IGM/research process. Inclusion of foreign nationals will be advantageous as perspectives on recovery from varying contexts will add to the richness of the study

3.6.3 Exclusion criteria

- Traumatic brain injury or any other cognitive disorder that may prevent understanding of the interview and research process

- Participants who did not agree to more than one interview
- Participants who did not wish to be recorded

3.6.4 Participant profiles

Table 3-2 represents the profiles of all participants

PSEUDONYM	GENDER	AGE	DIAGNOSIS	NO. OF ADMISSIONS TO THE UNIT	NO. OF GROUPS ATTENDED	NUMBER OF INTERVIEWS
Rachel	F	56	Depression & Eating disorder in remission	1	16	3
Celeste	F	38	Borderline Personality Disorder & Diabetes	6	100+	1
Lucy	F	22	Bipolar	1	18	3
Monique	F	35	Chronic pain & Syringomyelia	1	16	2
Linda	F	20	Eating Disorder & Obesity	2	100+	1
Glenda	F	38	Anxiety	1	16	2
Charlie	F	45	Multiple Sclerosis	1 (Early DC)	10	1
Total number of hours of data collected during interviews	13					

3.6.5 Introducing the participants

Rachel

Rachel is a 56-year-old woman living in a Cape Town suburb with her mother and two adult daughters. She was diagnosed with an eating disorder in adolescence and had been having regular difficulties with her digestive system. It was her index admission to Unit X at the time of the research. Rachel was quiet and soft spoken, yet always willing to participate in the study. Rachel was interviewed 3 times during the research, twice within the unit and once at her home for the final interview.

Celeste

Celeste is a 38-year-old woman living in a Cape Town suburb. She was diagnosed with Borderline Personality Disorder (BPD), an eating disorder, diabetes and had recently had a lower limb amputation due to her poorly managed diabetes. Celeste had been admitted to the unit seven times over a number of years for extended periods of time and had therefore attended an estimated 300 groups in Unit X. When she joined the study, she had been in the unit for a number of months. Celeste was interviewed once for the study. She was not interviewed at week 8 or after discharge as it was assumed that her feedback would encompass her experience of multiple extended admission with periods of living in the community in between.

Lucy

Lucy is a young 23-year-old living in a Cape Town suburb with her partner. She is a student and works a part time job as an au pair with children. When the interviews started Lucy was living with her mother, and moved to her partner's place during her admission to be in a healthier and more stable environment. Lucy was eager to be part of the study and completed three interviews. Lucy was diagnosed with Bipolar II depressive type. It was her index admission to Unit X.

Monique

Monique is a young 35-year-old female living alone in the central part of Cape Town. She was diagnosed with chronic pain and syringomyelia. She is unemployed, single and has no children. It was her index admission to Unit X at the time of the interviews. Monique appeared to be frank, confident and willing to share her experience of the

groups in all interviews. Monique was seen for 2 interviews as she was not able to be contacted for the final post discharge interview.

Linda

Linda is a young 20-year-old from Cape Town living with a severe eating disorder. She was morbidly obese and reported that she had come to the unit to lose weight and to help change her lifestyle and herself. Linda had one admission to the unit prior to her current admission at the time of the study. When Linda joined the study, she had been in the program for five months, giving her exposure to 100+ groups over the duration of her two admissions. Linda was interviewed once for the study. She was not interviewed a second time or after discharge because she had been to multiple groups, over two admissions, and therefore she would have been able to provide feedback regarding the IGM and discharge as she had already been living in the community prior to the current admission. In addition, Linda had had an unusually long admission to the unit and a discharge date had not yet been determined.

Glenda

Glenda is a 38-year-old woman living in George with her family. She was diagnosed with anxiety and depression. She was quiet and soft spoken in both interviews. Glenda was hesitant during her initial interview, however was confident and outspoken during the second. It was Glenda's index admission at the time of interviews. She was seen for two interviews, the last took place two days prior to her discharge from the unit. A follow interview was not done because she lived in George, which was a significant journey to travel and did not follow up at Unit X post discharge. At her second interview, it was agreed that it would be the final interview.

Charlie

Charlie is a 41-year-old woman living in a suburb of the Cape Flats with her family. She is a mother of five and is extremely proud of her children. It was her first admission to the unit at the time of meeting. She was diagnosed with multiple sclerosis and depression. She was seen for one interview. She was discharged prematurely before completing the program and was not able to be contacted thereafter. Charlie was eager throughout her interviews and willing to share her experience and opinion on the groups.

3.7 Entry to research site

Access to the research site was secured through contact with the OT on the team who acted as the primary gatekeeper for the study. The research commenced after ethics approval was granted by Faculty of Health Sciences Human Research Ethics Council (HREC number 599/2016 -see Appendix C) and Provincial Government of the Western Cape (PGWC) (see Appendix D).

3.8 Data collection methods

Data was collected through one- on- one semi-structured audio recorded interviews using an interview protocol (see Appendix E) (Baxter & Jack, 2008) and observation of groups being run by and an occupational therapist using the IGM. A key feature of qualitative research was used in this study such as minimising the power relations that often exist between researcher and individuals by enabling MHCUs to share their unique stories through supportive interviewing and sensitive probing (Creswell, 2007). In this instance, qualitative methodology involved a people-centred approach (Lim et al., 2007).

The participants' medical files and clinical notes were not consulted during the research process to ensure that I remained objective by eliminate bias based on their diagnosis, and to allow participants to tell their own story, as opposed to one gleaned from their file. Permission to consult clinical notes was also not granted by PGWCW and therefore no secondary data was collected from documents such as OT notes about responses during the IGM run groups. All the information gathered was obtained from the participants with their informed consent. Ethical matters are described below.

3.8.1 Semi-structured interviews

For a study of this nature semi-structured individual interviews (Srivastava & Thompson, 2009) with MHCUs were indicated rather than focus groups because the

latter method is too closely aligned with groupwork as the primary therapeutic modality and with the IGM itself. The interviews were carried out at a mutually suitable time using an interview protocol, with guided conversation (Srivastava & Thompson, 2009). The interview schedule (see Appendix E) was followed strictly using the predetermined probes. The same interview schedule was used at all three interviews. The mental state of participants was monitored prior to the interview through consultation with nursing staff on duty and throughout the interview process by using my clinical skills as a mental health occupational therapist (see 3.14 Ethics). Participants were informed of the support resources at their disposal and were reminded that they could stop the interview at any time, and should they require a referral to the mental health nurse, a referral would be made. None of the participants required this step.

The interview guide was developed using a review of groupwork literature to ensure perspectives are gathered about potential group dynamics, group facilitation and group processes arising from the activity centred IGM approach. In addition, a review of the recovery literature ensured that perspectives were gathered about links (or not) between the specific approach of the IGM and the recovery needs of participants.

A pilot interview was conducted to refine the interview schedule (Van Teijlingen, Rennie, Hundley, & Graham, 2001). It was conducted with one MHCU before the main study commenced. The MHCU was recruited via the occupational therapist on Unit X. Informed consent was followed when approaching this participant (see Appendix G). Data from this interview were not included in the main data pool because she was assessed as having mild intellectual disability during her admission. Despite the diagnosis, which was made after the pilot interview, the MHCU's engagement with the pilot interview nevertheless enabled minor changes to be made to the interview guide, for example, where questions were loaded, and required a detailed answer they were split so that participants were able to consider each aspect of the question. Participants had a copy of the interview schedule during the process ensuring they were able to follow the interview as it unfolded. Questions were repeated and explained, as simply as possible, with careful attention not to lead the participants.

3.8.2 Observation

Direct passive observation of three groups from behind a one-way mirror was conducted prior to commencement of the interviews by the researcher. Informed consent to observe the group was obtained from the team and group members prior to the commencement of the group. Observation notes were taken (see Appendix F₁) based on the following guidelines of the documented structure and theory of the IGM. The observations were used to inform probes used in the semi-structured interview (see Appendix E). No pilot of the group observation was conducted. Aspects identified were:

- Structural and organisational features were noted under the headings: microcosm, interactiveness, direct communication, here & now and leading from behind. Observation of the steps of the IGM included the steps: intro, norm setting, meet group at emotional level, warm up, bridging, activity, feedback or norm setting, post discussion activity and closure.
- People's interaction with each other, the OT and the selected group activity, including what group members did, said in the group, and paying careful attention to objective signs of changes in mood and interaction.
- The emergent group process in relation to the IGM structure and dialogue that pertains to recovery was observed, paying careful attention to the key issues that arose in the session as well as the links raised by the participants in relation to the elements of recovery.

3.9 Data collection process

I conducted all the interviews. Full disclosure regarding personal interests in the study and profession was clarified at the beginning of each data gathering event by means of the informed consent covering letter and form (see Appendix H) signed at each meeting. Their right to withdraw from the study at any stage with no consequences was reiterated each time the MHCU was approached for an interview.

Each sampled MHCU was invited to participate in three semi structured interviews of approximately 40 minutes each at week two, week eight or twelve (if s/he was in the

eating disorder programme), and four weeks post discharge. The rationale for these points in time was as follows:

- Perspectives on IGM after the first week's exposure in the unit. The participant had to have been exposed to the model at least once to participate in the study. This time period also allowed the participant to be settled in the unit and to understand where occupational therapy fitted into the programme.
- Perspectives on IGM at week eight: The participants may have had a different experience or perception of the IGM after numerous exposures to the method.
- Perspectives on IGM at or after discharge at a one month follow up: The participants would be able to reflect whether the IGM made any contribution to their recovery (or not) post discharge when the recovery process was most applicable due to the occupational performance demands of community re-integration. The duration between interviews was deemed relevant for the full impact of the IGM on change in recovery status to be experienced.

The interviews were recorded on a Dictaphone with permission and were conducted in a quiet and comfortable room within the unit to ensure a safe and private space. The participants were offered the opportunity to choose a venue that was comfortable and convenient for them for the final interview post discharge. The same interview schedule was used at all interview points.

In summary, MHCUs were exposed to the IGM at least 8 times during their admission. Data was collected at the following points for each of the participants depicted in Table 3 below. Reasons for not completing three interviews are also reflected.

Table 3-3 Schedule of interviews for each participant

Participant pseudonym	Week 2	Week 8	4 weeks post DC	Other
Rachel	X	X	X	
Monique	X	X	*	
Lucy	X	X	X	
Celeste	*	*	*	X (after being in the unit for 5 months)*
Linda	*	*	*	X (after being in the unit for 9 months)*
Charlie	X	*	*	
Glenda	X	X	*	

*See reasons for deviations in interview schedule in paragraph 3.6.5

3.10 Data management

Interviews were audio recorded, and transcribed verbatim into text documents (Creswell, 2007). Subsequent to transcription, the data was organised and electronically filed, with back-up copies both on hard drives and Google Drive (Creswell, 2007). All the data was password protected. Participants were given the opportunity to choose pseudonyms, and for those that did not, pseudonyms were allocated and were used throughout the transcribed data (Creswell, 2007). Researcher observation notes (using pseudonyms) were locked in a cabinet that only I had access to.

3.11 Data analysis

I transcribed the audio-recordings and was therefore immersed in the data at an early stage in the data analysis process. Line by line coding was used to code the raw data into meaning units (Charmaz, 2014). Inductive analysis moved from specific to general until particular patterns of meaning emerged from the identified codes (Vaismoradi, Turunen, & Bondas, 2013). These patterns were captured into sub-

categories, categories and a theme related to MHCU's perspectives on the IGM and recovery (Creswell, 2007). During this process, I drew on the work of Creswell (2007, p. 185) referred to as "winnowing" the data. Each individual interview was analysed, thereafter all data was combined and winnowed to identify a common theme. Evidence of the data analysis spiral (Creswell, 2007) that was followed is available in Appendix I.

3.12 Trustworthiness

Lincoln and Guba (2011) suggest that the trustworthiness of a qualitative study can be assessed by establishing the plausibility of the findings according to the following four elements.

- **Credibility**

The findings are credible when they offer a true representation of the participant's original data through verbatim quotes (Lincoln & Guba, 1985). During the research process I received peer debriefing in the form study supervisors to enhance my understanding of the data. I also made use of triangulation (OTGrow documents and researcher observations) and member checking of study findings with interviewees. I verified the credibility of the findings by presenting them to the participants for comment on whether they represented their personal views on the IGM (Lincoln & Guba, 1994). I requested them to review the transcripts of their interviews so that they had the opportunity to comment on what was captured. Member checking was also used to ensure that the voices of the participants were carried through in the anonymous representation of their perspectives, using quotes. Participants had the opportunity to comment on whether the quotes captured the essence of what they were trying to bring across in the interviews. Participants were given the opportunity to add to the data during member checking. Participants that participated in more than one interview were given the opportunity to view their personal data that was analysed. In addition, they commented that by reading their quotes it assisted them in making sense of their progress and healing to date.

- Transferability

‘Thick description’ of the perspectives of purposively sampled participants about the IGM give the readers of the research report a sense of the alignment between the assumed benefits of the approach to occupational therapy groupwork by proponents of the IGM and MHCUs views. Although the findings are not transferable or generalizable, they nevertheless inform South African OTs by highlighting benefits and limitations of the approach. The most advantageous aspect of transferability may be MHCUs recommendations for refinement of the IGM.

- Dependability

Dependability was ensured by the creation of an audit trail. A visual diagram substantiating the data collection, analysis and interpretation was developed to serve as an exemplar of dependability and for replication by future researchers (see Appendix J). Lincoln and Guba (2011) propose that a competent peer be appointed as an auditor to address dependability and conformability. In this research, the university supervisors oversaw that the audit trail was effectively executed (Lincoln & Guba, 1994).

- Conformability

This element is described in Lincoln and Guba (2011) as a measure of how well findings can be supported by the data that has been collected and that the findings are a reflection of the data and not of the researcher’s assumptions. My reflexive journal assisted me to circumscribe my assumptions and suspend my personal beliefs about the IGM and its contribution to recovery. It is acknowledged that in qualitative research, the researcher cannot be separated from the study, and therefore the acknowledgement of the researcher’s role, background and assumptions and their influence on the study were clearly stated (see 3.4 above).

- Reflexivity

Throughout the research process observations and reflective journaling was carried out which contributed to the data collection process. Keeping self-

reflective journals was a strategy that facilitated reflexivity, where I examined my personal assumptions and goals as well as clarified individual belief systems and subjectivities (Ortlipp, 2008) (see Appendix K). The journal did not form part of direct data but was rather be used to enhance objectivity during data analysis (Ortlipp, 2008).

3.14 Ethical considerations

3.14.1 Risk and vulnerability

This was a medium risk study as the MHCUs of this facility were vulnerable due to their multi-diagnostic needs such as general medical conditions, personality pathology and mental illness. I am a trained mental health professional with experience in specialized psychiatry and used my skills in assessing mental state before and during the interviews. I checked in with both the unit OT & nurse on duty prior to beginning the interviews to be certain of participants' mental state. Informed consent was obtained prior to commencing each interview. I explained my role in the research in that I functioned as an independent professional who was not a member of the treatment team on Unit X, in an effort to reduce the power imbalance.

There was minimal harm associated with the research questions, however if participants required assistance in working through their concerns about what they reveal about the IGM method or request it, they could have been referred to the mental health nurse or psychologist. No participant required this intervention. Non-maleficence was ensured by the researcher clearly communicating the motives for the study with the participants. It was anticipated that the altruistic benefits of participating in the study would counterbalance negative feedback about the IGM.

3.14.2 Autonomy

When participants were approached it was ensured that they were not coerced into participating, understood what the research method entailed and that their participation was entirely voluntary. Informed consent was obtained (see Appendices G and H) and the participants were informed that they could withdraw from the research at any time without penalty.

3.14.3 Beneficence

It was communicated to the participants that it is the responsibility of the researcher that the findings are presented at the correct forums, such as Occupational Therapy Association of South Africa (OTASA) congress, The World Federation of Occupational Therapy (WFOT) and Metro Occupational Therapy in Health (MOTH) district forums so that other occupational therapists using the IGM are informed about MHCUs views on the relevance of the IGM to their recovery. Participants were told how the research would be presented and if the opportunity arises, published (Orb, Eisenhauer, & Wynaden, 2001).

3.14.4 Justice

Smith (2008) suggests that implementation of justice should not further burden an already vulnerable group of participants. The research provided an opportunity for a vulnerable group to share their views pertaining to a particular type of treatment received in Unit X. As such, the method provided some form of justice towards a ‘people-centred’ (Western Cape Government, 2013) health service in specialist psychiatric treatment units. It is the responsibility of the researcher to share the study findings with various stakeholders in other settings where the IGM is used, in particular through OTGrow, the main proponents of the IGM as well as OTASA who support the Position Statement on Groupwork in the profession.

3.14.5 Confidentiality & informed consent

Pseudonyms were allocated to all participants to ensure confidentiality. Participants were informed that electronic data was password protected, and hard data locked away. See Appendices G and H for informed consent forms. The participants were informed of the aim of the study, how the data was to be collected, stored and safeguarded. Informed consent was obtained prior to each interview.

3.15 Summary

In this chapter, the social constructivist theoretical approach was outlined, and the descriptive qualitative design chosen for this research was motivated. The research context and participant selection and process were explained. Information pertaining to data management, ethical considerations and the approach to trustworthiness was detailed. Given the social constructivist lens within which the research was framed, the findings of the research are presented in the next chapter.

CHAPTER 4: FINDINGS

4.1 Introduction

One theme emerged through analysis of participants' collective perceptions on the contribution of the IGM groups to their recovery. The theme; 'Helping me to navigate life while living with my illness' consisted of 2 categories namely 'learning through the group space' and 'learning that the journey is never over'. These categories had 5 subcategories namely 'engaging the activity', 'participating in the group process' pertaining to the first category, 'experiencing the group structure', 'recognising personal shifts' and 'acknowledging 'stuckness'' pertaining to the second category, as outlined in Table 4 below;

Table 4-1 Findings

THEME	CATEGORIES	SUBCATEGORIES
Helping me to navigate life while living with my illness	Learning through the group space	Engaging in the activity
		Participating in the group process
		Experiencing group structure
	Learning that the journey is never over	Recognising personal shifts
		Acknowledging stuckness

In this chapter I presented the following: the theme was introduced after which the categories that make up the theme were described by systematically detailing and substantiating the content of each sub-category using quotes. It must be emphasised that Table 4.1 is dynamic in that the sub-categories interact to achieve the learning that is reflected in the two categories. The benefits and limitations of groups run using the IGM in relation to recovery were highlighted through the meaning units embedded in the various sub-categories.

4.2 Theme: Helping me navigate life while living with my illness.

MHCUs in this study perceived the contribution of the IGM to their recovery as being an intervention method that helped them navigate their lives while living with their mental illness. Navigating their lives as patients with a mental illness in a psychiatric unit involved learning in the group space through engaging in the activity, participating in the group process and experiencing the group structure. Importantly, the occupational therapy groups helped them realise that the journey towards mental health and recovery is never over because personal shifts happen best when one acknowledges and deals with ‘stuckness’. The benefits of the learning as it pertains to recovery was reflected through substantiating quotes. The limitations of the IGM approach were also captured through quotes.

4.2.1 Learning through the group space

The group space refers to the integrated experience of a single occupational therapy group session. Learning occurred through doing the activity, experiencing group dynamics and responding to the group structure.

4.2.1.1 Engaging the activity

The first benefit of doing activities pertained to increased self-awareness as explained by the following participants:

so it's doing activities that are different but with the purpose of you actually learning new things about yourself or learning how to improve on things about yourself. (Lucy)

I think being, getting in touch with certain feelings that is not really obvious, so in activities there would be certain things that came up for me that I couldn't really see, but was brought to my attention in the activity. (Celeste)

Ooh... We had to do those activities and each activity showed us an aspect of all our characters that there was always something that stood out. (Monique)

The quotes above showed that through engaging in the activities, the participants learned about themselves, particularly aspects that they were perhaps not aware of prior to engaging in the activities.

A second benefit of doing activities pertained to shifts in outlook:

It did help with attitude cause when you have attitude it affects another people. So when we have OT and you have that attitude, you gonna do some stuff there and you gonna be like I don't want to do anything, but when we play a game and you find this game is very interesting, you coming up out of that attitude and go more interested. (Linda)

with OT there is a way to cope. You know OT and many of the other activities is kind of teaching you a way, the coping skills that I reached out for to learn how to cope with whatever, and that changed my frame of mind. (Charlie)

A third benefit of engaging in the activity involved learning how to resolve conflict through better understanding of what giving and receiving feedback involves.

like why am I doing this, what's it got to do with anything or my recovery? But then when you get the feedback you realise, oh, I am behaving like this or yes I do that, then it is very helpful in order for change to happen and to be aware of that. So that, that happens for me when we do the activities. (Celeste)

Rachel added:

Well they said things about me that made me feel good and they said things that also didn't make me feel so nice about myself, but I learnt that they were honest. When I sat thinking to myself I thought yes I am that way sometimes or I'm not that way sometime. So it taught me a lot about myself and I've learnt

to tolerate people better, to not look down on people and you know, not to be critical you know, I mean not to badmouth people and to have patience. (Rachel)

It is interesting to note that participants transferred their learning in the OT groups sessions to their everyday life and by inference, to their ongoing recovery.

Like how to speak to someone else appropriately and what to avoid and then I also think that conflict resolution is some form of a skill because it's something that will always come up, not all the time but it's always going to be a thing. So I think its a skill to be able to resolve conflict in a mature way and then that also helps with your thinking and your solutions.” (Lucy)

So even though we so different we have to make it work to be a success in whatever we are given to do. So that is the same outside. At work we are different people, different genders, and different ages and sometimes we do differ in opinions. So what that has taught me here is to respect others if we differ in opinion and sometimes we just have to agree to disagree, without me feeling lesser than the next person or without me judging the next person. So yah. (Glenda)

The activities also offered an opportunity to learn other skills.

Especially communication skills. I didn't have those. It has helped me and improved my communication skills a lot. (Glenda)

The activity was not always perceived as beneficial or comprehensible in terms of recovery. Limitations pertained to feelings of being infantilized and finding the learning tedious and repetitive.

The first limitation related to participants feeling infantilized due to the activity choices used for OT groups.

The first few times I came to OT I wondered what do these stupid games have to do with me because they look silly to me. (Glenda)

So you come and you told to jump around and whatever. It's like, really, is this what we came to do here and it can be, I'm not three years old type of thing. (Monique)

We had to do some things like things that we, that I used to do when we were 7 years old, these little paper things and I wasn't sure what was going on. (Monique)

The second limitation related to the activities used not being relevant to dealing with the difficulties the participants are experiencing and working on in the unit.

I think that sometimes with OT something gets lost in the fun or in the amazement of whatever is happening or is going on. Then people may lose perspective, exactly why we doing it. (Monique)

I can think of that maybe wasn't useful for dealing with our issues because we were just playing a card game. (Lucy)

The third limitation related to activities that were repeated regularly in the OT groups, resulting in group members having to engage in the activity more than once during their stay.

But another thing that I think that they could change in the OT is uhm, ... while I was there, the members that used to be in in the unit before in the group before, they used to say, "oh no not this one again... because it's the same like OT you know, things that she gives every year, year after year..." (Rachel)

The only downfall for me doing the activities is that I know what's going to be expected I almost know, it's like I'm doing play. No, okay so now it's going

to feel like this this for me, no change, so it gets a bit tedious and like what am I actually doing to change here because I already know like what's expected and those types of things, so it can be quite disappointing. (Celeste)

It can be very disheartening for me to come here and it's the same thing again, like even in one admission it can be like the same activity maybe four times and it can be like oh god, like it's so discouraging I tend to sort of fade away, not really listen... I tend to get very bored and very despondent when that's happening because it's not new for me so I don't really know what else to search for, so I like I said it can be very boring... (Celeste)

Cause it's been a long time now, cause the first time I was here it was helpful and even now it is but I already know what we are going to do with that session. (Linda)

The participants also made recommendations that could be implemented to improve their experience. With regards to selection of the activity, participants recommended that it be more appropriate for adults and that a wider range be selected.

if they could incorporate more adult things, games because I think you do get quite a lot of them. (Rachel)

Like to change completely because it's mostly stuff to do with paper and glue and crayons and khokis, it's sort of like the same thing. (Monique)

In addition, a suggestion was made to change the structure of the session:

I think maybe before we start the group, we could have a warm up session where we do a few a exercises or do something to wake us up like if you look at everyone's faces before we begin its like oh no must we do this again, or they're tired and yawning and they're not into it. (Rachel)

4.2.1.2 Participating in the group process

The group process refers to the dynamic procedures through which the group approached a set of common issues. Benefits of participating in the group process related to changing the way participants perceived themselves, increased mindfulness, reflection and self-expression.

The first benefit of participating in the group process was self-expression.

The session really help express exactly what you are struggling with. (Linda)

...just to be able to express ourselves more in general because in OT groups you are not allowed to just sit there and not participate. In saying it out loud you realise that it actually does matter... There's no more bottling it up. There's no more stifling or pushing it away. I speak about it and I'm not afraid to speak about it. (Lucy)

uhm I still tend to bottle up my feelings but I can express them more easily now, much more than before, like before I didn't want to express any feelings, like even when I'm sad, I used to keep the tears in you know? I didn't want to cry, or show my vulnerable side... (Rachel)

The second benefit of participating in the group process related to having an opportunity for reflection and to develop mindfulness

...to change the way I look at myself. (Linda)

yah...learn about yourself. You learn about life, certain situations and other people around you. (Monique)

Like you just doing it and you mindful of what you doing but then afterwards you actually reflect and think... how did I feel doing that? What have I learnt about myself, what can I change in the future. (Lucy)

Participating in the group process promoted learning because it evoked the participation of all members working, thinking together and communicating with others. The participants also appreciated the group process as it was flexible to the emergent needs of the group. They acknowledged that the group elicited cognitive demands and matters were addressed in the here-and-now, allowing for immediate resolution of difficulties within the group space.

Intrapersonal benefits of participating in the group space included learning about relationships and the value they place on them. Participants' views were as follows:

It helps me to have better relationships with my family and see the role that I play in my family's life. It's really important to me, I guess it's any relationship I've come across, it's helped me realise what relationships are to me and how they're important to me and what are roles that I need to play? I mean I've always had a difficult relationship with my family but being in the group helps me become aware of my contribution in the relationship, you know if there's things I want in the relationship, how can I get it? How can I work on having a better family life or better friends or just general life, and frustrations and irritations and just generally helps me to become more aware of that. (Celeste)

The participants also learnt through experiencing feelings of cohesion and being a unit and recognising that participation in the group mirrors the difficulties they have on the outside.

uhm, I think it brought us all together, as a unit, as one... ya, it's like no one felt isolated we were all like brought together after the group. We all had to do a little bit to make it work. (Rachel)

There are links, definitely everyday all the time because we do have disagreements sometimes, not sometimes, all the time because we are different people with different beliefs and upbringing and how we see certain things. What is acceptable to me might not be acceptable to the next person and yet we have to work in one group and we have to make it work. So even though

we so different we have to make it work to be a success in whatever we are given to do. So that is the same outside. Glenda

As limitations, participants raised that the groups elicited uncomfortable feelings and that the purpose of the group can at times be lost. They did however acknowledge the perceived discomfort of participating in the group process was a necessary part of the recovery journey.

... which helped me to uh become aware of my behaviour, which sometimes could be quite painful, you know I would maybe break down, or be angry, or it would bring up some kind of emotion that is in the subconscious... (Celeste)

That was my first time giving feedback or participating in a OT group because before that day, I was not comfortable to talk so I would just sit and listen in to others, but that day, I can't actually remember what the whole thing was about but the OT, she touched a nerve and I like totally broke down. (Glenda)

OT groups...I do like OT groups but for me it's like when we go to OT group we know we going to talk about our feelings so for me sometimes I am not ready to say exactly how I feel... (Linda)

I think that sometimes with OT something get lost in the fun or amazement of whatever is going on. Then people may lose perspective, exactly why we are doing it. (Monique)

4.2.1.3 Experiencing the group structure

The group structure refers to the internal framework that defines how time is used during the group and how members, including the therapist, are expected to relate to one another. Participants found the combination of activity and discussion helpful because it allowed the group to be more comfortable and relaxed.

The MHCUs perceived the activity and the group procedures as providing structure.

Umm... So firstly I think it provides a structure to the group. So you are not just going in there and then things are chaotic. You going in there and there's a structure to the group. So warmup, activity, discussion. You not just going in doing something and then leaving. You're going into a group, you are participating in an activity and you are reflecting on it afterwards. (Lucy)

The second benefit of experiencing the group structure related to how the warm up and activity assisted the group in feeling relaxed, and how the activity itself assisted in facilitating interaction and eliciting emotion, which is discussed thereafter.

So that stuff I find is very helpful but you know, you can't just talk all the time you know, you have to sort of mix it in with an activity. (Celeste)

It [the warm up] sort of paved the way because if it had to happen that we go straight to the serious business, I think I would feel uncomfortable but now we play a game, I enjoy it or I get frustrated and then she asks me "How did the game make you feel" and then there are other people involved like when we work in a team she would, like press the emotions out of me. Did anyone frustrate you? Why were you frustrated? And she would take that and bring it back to my own life and it was easier then to relate and open up and yah...that's what I like about OT...it helped me to open up. (Glenda)

In the study, it emerged that the group experienced limitations which were linked to the structure of the group. The first of these were due to the various levels of functioning between the group members. Higher functioning members found this frustrating, but also acknowledged that they may have similar experiences outside of the group space.

It's not like school where there will be like, this is like grade one and this is grade two. So everyone is just there. Some people are just completely lost. Sometimes we have to explain things to each other afterwards like at the dinner table, someone will be like...Aah...that was so...or what did that mean? And

some people just think it was useless, I should just go and sleep. Then someone else may have understood it. I dunno how that can be balanced out, but again I suppose, that's life. You don't always mingle with the people who are always at your level of I suppose, education, understanding, same IQ and all that I suppose. (Monique)

The second limitation was related to the duration of the groups:

sometimes two hours can be draining especially if I talk about emotional stuff.
(Glenda)

The third limitation was linked to the artificial nature of the groups as they are not situated in real life. This finding is particularly significant because it suggests that the structure and content of the OT groups did not resonate with the demands of 'real life' and by inference, with recovery post discharge.

... all this is theory, like we do like a thing here, like make a poster and yes you realise, like I said, you now know that this is what life is about. It's not like putting you out in a field out there somewhere so that you actually implement those things with an OT there and you are sitting in a restaurant and a waiter is rude to you. Its different, this is. We know it's a game. So at the end of the day, you can participate and then when you feel it's too difficult you can just be like Ag. After all nothing really is going to happen if I, for instance, it's all pretend. (Monique)

told there are no silly questions, there is no right or wrong answer. Of which, life is not like that. There are silly questions in life and there are things that are like wrong that you know, things have consequences, but here there are no consequences. It's a game. It's all pretend, so the whole thing, some people might actually miss the point or implementing it out there may be difficult because now you are actually faced with a situation that does have consequences whereas this doesn't. (Monique)

4.2.2 Learning that the journey is never over

The learning in this category occurred through the realisation that recovery from a mental illness involves gradual personal shifts and dealing with times of feeling stuck, and most importantly, that the journey is never over.

4.2.2.1 Recognising personal shifts

Benefits of participating in OT groups related to changes in their attitudes towards their illness and their understanding of recovery, and they began to realise that a meaningful life is possible despite having a mental illness.

The first benefit related to recognising personal shifts was related to understanding what recovery means to them, an awareness of difficulties that accompany their illness, as well as considering the skills that can be employed to manage them.

I think recovery means being honest with yourself, uhm and sometimes that means dealing with emotions, or, or noticing behaviour things that you don't want to really sort of face. So that's, that's really what OT's done for me..... So yes, I think it takes a lot of practice because you're not going to learn the work quickly where you have an issue or an episode where you automatically think OT stuff but it does become more easier if it is practised and it is stuff that you can take to use outside. Definitely. Ya. (Celeste)

The second benefit of recognising personal shifts pertained to their attitudes towards values and their illness.

I always thought that Ag...what's the use of my life it's full of problems... as if something is going to happen so my attitude towards life is slowly, surely changing. (Glenda)

I thought about living a healthy lifestyle whereas before I didn't. I value things more now than I did before, like little things. (Rachel)

The third benefit of recognising personal shifts was where a participant learnt about ending stigma within herself, as well as living a healthy and meaningful life, even in the context of mental health concerns.

It has because I think a lot of people have a lot of self-doubt particularly when you have a mental illness and so in doing all of the OT groups and in bringing up all of these issues and learning so much about myself and learning all these valuable things to build myself up and to communicate in a healthy way, I think that in itself showed me that even if I suffer from a mental illness, I can still live like everybody else or people who don't suffer from mental illness. I think the groups also helped a lot for me to end the stigma within myself about mental illness ... (Lucy)

4.2.2.2 Acknowledging stuckness

Participants indicated that the recovery journey also involved dealing with stuckness, when things didn't change and it was difficult to remain positive.

So when I think about my situation, I have this illness, I have the best surgeons working on my surgery and stuff and I had an expectation of getting over the pain and stuff but now I've had to live with chronic pain and everything that I have done so far has shown me that pain is always going to be part of my life. So what do I do now with my new reality? So that is it. I am just having to look at it from that perspective. It [OT group] has helped me change my perspective on, you know on looking at my illness, dealing with it. I thought that by now I would be getting better but I seem to like what...they say you get worse before you get better so I think this is the worse now. (Monique)

So it's difficult but it's helpful. I mean feelings are feelings, you can't really change them. But helps me become aware that if I have a feeling now this doesn't, how do I deal with this? If I'm frustrated am I going now call someone a name? It just helps me feel more sort of contained, especially someone like me who's got borderline. I don't manage my feelings very well, so this makes me more aware like what can I do in the time that I'm feeling frustrated or angry, like what techniques can I use or how can I slow myself down so that so that I'm not going to be damaging towards myself or others and more like more of a containment, more of a thought process rather just like oh, I'm just going to be like or behave like how I've always behaved. So that's been difficult but, ya. (Celeste)

4.3 Summary

In this chapter, the findings that MHCUs in this study highlighted the perception that OT groups contributed to participants' social connections with others in interpersonal functioning and helped them acquire skills to assist in coping with life while recovering from a mental illness. They reported limitations of the model with regard to repetition of activities, the choice of activity and their relevance to recovery. Lastly users described their recommendations on the refinement of the model such as length of the group, rotation of activities, setting change as well as an emphasis on the individual's journey of recovery.

CHAPTER 5: DISCUSSION

5.1 Introduction

In this chapter, the findings of this study with other studies that focus on the benefits and limitations of group therapy from the perspective of the MHCU were discussed and contrasted. The relevance of OT groups using the IGM for recovery based practice in mental health setting were discussed. It also considered the OTASA position statement in relation to a changing health system, with evolving demands, and where groupwork is an everyday requirement in services.

5.2 Activity as means vs activity as end: The question of occupation and occupation based therapy

A study conducted by Kelly, et al., (2010) emphasised the link between occupation, recovery and mental health. The findings emphasized the importance of occupation in relation to active participation in life, barriers to occupation and making a full mental health recovery. In particular, the participants described recovery as an occupational journey involving responsibility, active choice, empowerment, hope, and meaning.

The study stated that key factors that influenced recovery were: the participant's knowledge of recovery; re-establishing a self-concept in a safe and supported environment; possible barriers to occupation and the overarching necessity for engagement in occupation to promote; and maintaining mental health. The current study found that participants had varying degrees of understanding recovery. Participants also learnt about themselves from feedback and reflection within the group space. Similarly, Kelly (2010) found similar results and speaks of how a supportive group environment was key in re-establishing self-concept. Other key factors as stated by Kelly (2010) appear to be absent in the feedback and findings from the present study. The assumption of the IGM is that psychiatric and mental health

concerns are rooted in poor social relationships resulting in unhealthy interpersonal patterns, and therefore, the focus is on addressing these unhealthy and maladaptive behaviours in and during the group space and process. It is evident that the IGM is able to positively influence the social difficulties of MHCUs using activity as a catalyst. It is unclear whether the focus of the IGM is occupation based.

The IGM makes use of activities as the centre of intervention, a powerful catalyst for the group process. Activity is a valuable tool in eliciting a number of responses and outcomes in group intervention. According to Pöllänen, (2015) meaningful leisure activities appear to enhance wellbeing in that they foster hope and positive moods. These types of activities that evoke these positive types of experiences are activities that provide a sense of 'flow'. This term is used to describe a state of optimal experience where one engages in an activity simply for the sake of the activity itself, and the absorption in what one does (Nakamura & Csikszentmihalyi, 2009). The notion of activity as means and activity as ends described above is clearly evident in the research findings, and the link between activity and improving health and overall wellbeing and thus recovery. The challenge will always be ensuring that the activities are meaningful.

Activity as end, as an approach of the IGM, has clear benefits in enhancing overall sense of satisfaction, health, and wellbeing. Though the findings did not indicate that many of the participants described creative and craft like activities as pleasant, findings raised the mindless aspect whereby it took their minds off of their serious issues for some time. For some crafting is a medium of expression, others being able to experience a sense of agency and autonomy, in addition to a mindless distraction for others. Though the current study was not art therapy based, the task-centred and creative craft-like aspects can be related back to some of the literature. A study by Bell, et al. (2015) found that participants described their activities as leisure activities. They also reported that through the engagement in these activities it positively contributed to their feelings of satisfaction and overall sense of health and wellbeing as well as providing new interests. This agrees with Forzoni et al. (2010) where the participants rated art therapy groups as being 'helpful'. Forzoni et al. (2010) also found that only a small percentage of participants found the activities 'not interesting' and 'childish', whereas the vast majority of the participants found it to be 'relaxing' and

‘creative’. The same was evident in the current research, as a small percentage of participants found the craft and games groups to be childish, and to lack relevance to the service users and their recovery. The majority of participants found the tasks to be helpful in terms of creativity as well as ‘taking their minds off things’ so they did not have to think about their issues all of the time. Arts and crafts has a valuable place in recovery approach in mental health (Pöllänen, 2015). Activities such as crafts have a variety of benefits for individuals. For some the tangible benefit of the creator’s labour is an increase in motivation, while for others crafting provides tools for wellbeing. In both cases crafting makes it possible to strive towards a self-chosen goal that people value, which can help individuals feel better, therefore aiding in the process of recovery (Pöllänen, 2015).

Inclusion of arts and crafts in a recovery program can improve hope, create a sense of meaning and purpose, developing new coping skills and rebuilding a sense of self Spandler et al. (2007). It is therefore suggested that arts and crafts are included as part of the occupational therapy group program as it provides a package of care with recovery at its core. Finding and selecting activities that are relevant and meaningful to a vast range of group members can prove challenging.

The findings of the current study suggested that participants found the activities chosen for groups as infantilizing and irrelevant to their recovery at times. This could be due to the purpose of the activities as part of occupational therapy and the link to recovery had not been explained service users. Literature strengthens and echoes this aspect (Bell et al., 2015). Participants found it useful to highlight areas in practice that could be strengthened as it was important to understand the experience of the client in order to gain insight into the usefulness of the intervention programme (Bell, et al., 2015). In the current study, participants saw no value in the arts and craft groups and found them to be boring. The researcher indicated that the participants may not have clearly understood why they were attending those sessions, which could have led to their negative experience of the arts and craft groups. In a study by Dierick & Lietaer (2008) where clients’ perceptions of hindering factors in group psychotherapy were explored, the findings indicated unsafe or aloof climate; no personal change; feeling anxious or inhibited; finding groupwork frustrating; overstimulation and exhausting psychological demands; failing therapist, and group rejection (Dierick & Lietaer,

2008). When evaluating this against the current study, there are a few similarities. Participants in the current study raised factors similar to “no personal change” which can be found in the subcategory: acknowledging stuckness. It is within this subcategory where it is clear that there may be some ambivalence with regards to personal change and recovery. Findings of the current study indicated a number of frustrations with the group activities with a split of old and new members in one group with repeated activities. In addition to the split in the group, members, both old and new, described that it can be frustrating when the activities do not appear relevant to their recovery journey.

Findings raised that the activities used in groups were not always perceived to be appropriate for adults and would bring up feelings of infantilization. Participants did not raise that they would prefer not to engage at all, rather that the facilitator should include more adult games, which are readily available. This raises that service users are not always resistant to what they are engaging in, but rather the medium used. Furthermore, this feedback is valuable as it represents the voices of the participants

Other recommendations included a broader range of activities in the group. These comments were in response to those that had already attended a number of groups where the same activities were repeated. In addition to this, a participant raised that a planned and clearly set out program would be beneficial. Knowing what type of group you are attending as well as an idea of the content or theme of the group would be considered to be part of informed consent. Consumers should always have enough information regarding their treatment, which, in turn, assists them in giving consent. Activity as means is clear in the use of the IGM, where findings indicated the recognising various personal shifts in skills both in self-management as well as interpersonal interactions. Furthermore, participants also shared their experience of partaking in this IGM process. They spoke about difficulties in open communication, group learning and relationships. The category Learning through the group space indicated that the IGM elicited and assisted in improving aspects such as communication and expressing themselves, learning to give and receive feedback, obtaining different perspectives, which in turn improved their interpersonal functioning and relationships. Caruso et al. (2013) developed five subscales as a result of trying to capture how patients experienced groups within a community mental

health context. These were, sharing of emotions and experiences; cognitive improvement; group learning; difficulties in open communication; and relationships. These subscales can be directly related to the findings of the current study. Similarities can be made, in relation to the benefits participants experienced from being part of the IGM group process. Caruso et al.'s (2013) subscales relate to the social and interpersonal aspects of the IGM, which correlates if one considers socialization and improving interaction as one of the core beliefs of the model.

In the subcategory engaging in the activity participants described how the groups assisted them with interpersonal benefits such as communication. In addition, they described how the groups assisted them in improving the relationships with their families. This improvement stemmed from an awareness of the difficulties in relationships, including personal contribution to the difficulties and the motivation to make changes. Verma & Chaundhury (2017) found similar results where participants expressed significant improvement in psychopathology such as social withdrawal, decreased interest in interacting with significant others, affective blunting and low mood. Though the patient population of the current study differed significantly, as Verma & Chaudhury's participants were mainly diagnosed with schizophrenia, the results remain applicable to the study with regards to the symptom improvement as well as the fact that the groups were task-centred. These findings substantiate the findings in the current study.

The findings related to engaging in the group process holds similarities to the study by Verma & Chaundhury (2017), where participants described the experience of working together in a group, being part of a group finding solutions that required the group to work together as a unit to successfully fulfil goals, as well as form relationships within the group. Their study findings indicated that participants in the group were motivated to find solutions for their problems within the group. Groupthink (Janis, 1972) and group learning as part of the theory coined by Janis (1972) are common benefits of groupwork and have been well documented over a number of years (Hassan, 2013; Lunenburg, 2010; Rose, 2011).

The current research shared a number of similarities with Bell et al. (2012). They looked at the perceptions of adolescents on the usefulness of an intervention at a

substance rehabilitation unit, post discharge. One of the similarities they noted was that participants felt they benefitted from skills that could be practically applied to their lives. The life skills elements these participants found helpful were communication and assertiveness. This finding is supported by another study whereby participants highlighted communication and assertiveness training as the most beneficial key elements in staying clean (Bell, et al., 2015). Although the present study is not related to substance use, staying clean is an aspect of recovery which the present study is focussed on. There were a number of concerns and limitations that were highlighted in the findings related to the choice of activity and the relation to the MHCUs recovery.

Considering the notion of the occupational human, finding everyday life tasks meaningful, comprehensible and manageable are core variables in creating a sense of competence, which in turn impacts on health and well-being (Dennis Persson, 2001). It is therefore evident that engagement in occupation would be vital for recovery.

Engaging in occupation is vital in the participant's recovery journey (Kelly et al., 2010). Though the current study reflects a number of the factors mentioned in the study by Kelly (2010), the occupation focus does not appear to be evident. Kelly (2010) states that engaging in occupation is vital in the individual's recovery journey, suggesting that it should be part of an intervention plan as part of a recovery programme. The IGM's focus is on an activity, and activity as the catalyst for interaction in the group. Activity and occupation are not the same, and without an occupational focus, recovery intervention can lose some of its potential impact. The IGM also addresses socialization through activity with very little occupational focus. Engaging in occupation is necessary for health and wellbeing, therefore solely focussing on activity and socialization seems unfit to address and maintain overall mental health and well-being of those living with mental health concerns.

5.2.1 MHCUs perspectives on activity as means

Activity as means to an end, from the perspectives of MHCUs, is a strong concept that emerged through the research and the findings. Participants indicated that emotions were elicited through the use of activity which in turn catalysed discussions in the group. A number of studies as cited in Cowls & Hale (2005) confirm that the use of activities in groups is more effective than groups that are only verbally based. Participants enjoyed that the group was broken up by activities, and how expression took place through the activities.

A mix of activities within a group process was found to be a valued component of the IGM, as it provided different types of therapeutic experiences. They appreciated that the groups are not always solely focused on deeply emotional issues and that there was a space for discussion as well as laughter and lighter activity in between. Thus, it would be important to begin to unpack perspectives on group process and structure.

5.3 MHCUs perspectives on group process and structure

Group process and structure are well documented concepts in the literature. Groupwork literature points to the possibility of an individual being rejected by other group members (Lietaer & Dierick, 2015). Participants consistently raised their positive feelings towards the group as a unit, and that the feelings of acceptance in the IGM group space helped them to learn how to relate to and communicate with others. A possible explanation for the difference in the current findings and the available literature is that the study by Lietaer & Dierick (2015) was focussed on psychotherapy and growth groups. In contrast, the current study was an occupational therapy group, where activity was the focus and the means of intervention. Cowls & Hale (2005) believe that activity-based groups create a therapeutic milieu and provide an experimental framework that reinforces an inclusive atmosphere in the group. Thus, activity as an effective structural aspect of the model, is beneficial in acting as a catalyst for the group process, thereby raising the power of activity in groupwork. In

addition, participants reported that they experienced discomfort during the group. However, they were aware and acknowledged that it was due to the group process.

In addition to the perspectives on process, the perspectives on the group structure were raised. The participants found OT groups long and exhausting, and suggested that groups have varied durations. They indicated that closure of OT groups should be natural, and not based on a clock with a time limit. Similarly, in the Cowls & Hale (2005) study, participants indicated that they felt adequate time should be allocated for all group members to share in the group. This would pose a problem within a setting where programmes are rigid and structured to promote efficiency and provide therapeutic containment (Bowers, 2014). Structure and boundaries are a vital part of the recovery and healing journey in therapeutic wards such as Unit X (Fisher, 1994).

5.3.1 Activity repetition and learning

Repetition of activity was highlighted as a limitation for the participants in the current study, in contrast to findings reported in the literature. Participants felt that the experience for both the old and new members was tainted with the repetition of activity. Older members were frustrated as they had already participated in the various activities offered by the model. In other literature, a difference was discovered where participants found value when groups such as stress management or coping mechanisms were repeated as it built on previous knowledge and allowed for the mastery of skills (Cowls & Hale, 2005). A possible explanation for the difference in findings could be that the IGM repeated activities as a means to allow themes to emerge over the lifespan of the closed group, whereas the groups in the Cowls and Hale's (2005) study had predefined themes with related activities and therefore a different purpose. It would be of value for research to note which group structure had the better recovery outcomes for this specific client population as Cowls and Hale (2005) also found it beneficial and useful to have these groups repeated so participants were able to gain more information and understanding around the topics. It is important to note that at the core of the IGM is Yalom's groupwork theory (Yalom, 1975) which encompasses group dynamics. By repeating activities, the therapist is

knowingly or unknowingly introducing a split in the group as some of the members would have already participated in the activities. This in turn could have an effect on the motivation and participation between the members of the group.

Even though units may have defined admission periods, this may vary depending on the needs of the MHCUs. It is difficult to alleviate repetition of activities during longer admission; however, a consideration could be made with regards to relevance of activities. If MHCUs in the unit were able to engage in meaningful activities and occupations that they have chosen, they may experience the repetition of activities differently. Developing a programme that meets the needs of the MHCUs is challenging, however with involvement and collaboration with the MHCUs, some of these challenges can be alleviated.

5.3.2 Group space and interpersonal learning

In previous studies of service users perceptions, findings have shown the therapeutic factor most valued by MHCUs in occupational therapy groups was the sense of being accepted by others in the group, gaining success, interacting with others, and hope (Eklund & Bäckström, 2006). The category 'learning through the group space' described how the participants perceived their learning in the IGM based OT group through facing personal shifts. They placed value on the acceptance they felt in a non-judgemental space, even though they had previously raised issues of frustrations with the group split. Readiness to relate to information in the group setting is dependent on where service users are within the process of understanding, accepting and dealing with their illness (Nair-Semands & Lese, 2000). Little value is usually recognised in groups, until there is more understanding and acceptance of the mental illness or mental health concern (Cows & Hale, 2005). When participants are at various stages in recovery and groups are compulsory, it can pose some challenges to motivation and participation. Cows & Hale (2005) suggested that when group members were on the same level of functioning and similar levels of recovery, it assisted them in feeling more comfortable in groups, facilitating opening up and participating. With links to the current study, findings suggested a strong emphasis towards being accepted in the

group space. In high pressured settings, where the requirement for all MHCUs in a unit is to receive some sort of intervention, service users may be admitted to a unit with mixed levels of functioning. However, clients are expected to attend groups, even though they may find the content challenging and above their particular levels of understanding and functioning. The difficulties that may arise as a result of varied levels of functioning in one group can somewhat be addressed with ensuring that the group space is safe, the members feel accepted, not judged, as well as some members who are at a similar stage in their recovery assisting members comfort levels.

A common concept reported in the literature is that of the notion of hope (Eklund & Backstrom, 2006). One of the key findings in this study was that participants indicated that the groups assisted them in gaining hope. Hope is essential to building a life. Without hope, coping with life proves difficult. Hope is seen as the combination between empathy and respect for an individual's life, as well as respect for an individual's capacity. The present or reality of 'what is' can be painful and frightening at times because of the illness, symptoms, past experience, prejudice and discrimination. It is important for these experiences to be validated and integrated in order for the individual to start rebuilding their lives. Providers empathise with the individuals situation in life and facilitate the identification of aspirations and goals, as well as provide the knowledge, skills, support and the resources to achieve them (Spaniol, 2009).

A study conducted by Eklund (2008) discovered that both patients and therapist highly valued group cohesiveness, instillation of hope, and interpersonal learning, which is similar to the findings of the current research. Cohesiveness and instillation of hope are part of the findings in the current study and has been addressed above. The subcategory "recognising personal shifts" was derived from participants reporting that groups assisted in teaching participants about relationships and realising the importance of relationships and the role that they play in them. Though it may be challenging to ensure that programmes and groups always instil and contain the element of hope, it is a valuable element in recovery practice.

In studies by Mc Nair-Semands & Lese (2000) and Kivlighan & Goldfine (1991) it was uncovered that, as members spent more time in the groups, the strength of the therapeutic factors increased and changed. Another finding was that the perceptions

of therapeutic factors may have been consistent with group members' present interpersonal problems. The experience of continuing group therapy participation would appear to be related to a significantly enhanced feeling of being similar to others (universality), an increase in hopefulness that problems will be resolved, and a stronger sense that group members are imparting information used to alleviate distress. The perception that family roles are being re-enacted in the group, the sense of group cohesiveness as well as the perception that disclosing with a cathartic process is also increased with time in group therapy (Macnair-Semands & Lese, 2000). In the current study these concepts are both supported and disputed by different participants.

The majority of the participants became more hopeful during their stay in the programme and attending groups. Considering the subcategories recognising personal shifts and acknowledging 'stuckness', it is clear that the findings are consistent with previous findings in the literature. It is clear that the experience of being part of a group is highly valued and an integral part of healing.

5.4 Recovery and the IGM approach

5.4.1 Recovery based programmes: the inherent requirements

Recovery based programmes should involve participation. Consumers need to be involved in all aspects of their treatment and recovery process. It should be assumed that they are able to participate even when it may not appear that they can, as recovery is a personal journey which is consumer driven and moves at the pace of the individual regardless of the expectations of the provider. Encouraging participation is labour intensive for the provider, however this may shift as the individual develops confidence in their ability to act in their own interest (Spaniol, 2009). The internal conditions that need to be present for recovery to take place are: hope that recovery is possible with the frame of mind to allow that to occur; an understanding that healing is fundamentally different to cure with a strong emphasis on the self as opposed to control of the illness; empowerment as an aid to correct hopelessness; and lastly

connection with society and knowledge (Jacobson & Greenley 2001). The latter condition is pertinent in terms of the relevance of the IGM approach. Participants acknowledged that the group space, though powerful, is artificial and raised questions about the transfer of learning to and relevance for their real-life situations. Simulated intervention lacks the real-life consequences and learning opportunities that learning through life brings. These findings are reiterated in the findings in another study where the theme “Take us out into the life” emerged in which participants wanted a more practical approach to life skills (Bell, et al., 2015). Participants found that it was easier to remember a skill learnt outside than a conversation. They were aware that by not engaging in real life situations, where skills can be practiced, the life skills may lose their value and impact that they may have had with practice in real life situations. This can be a challenging aspect of programme development and groupwork practice in mental health as a real-life exercise is not always possible due to institutional policies and structures. Thus, it is imperative that learning can either be generalised or experienced in real life situations. It is the real-life learnings through the group space that will foster healing and encourage the recovery journey.

Considering the findings of the current study it is clear that the IGM encourages hope for recovery and assists in changing the perception of users and the frame of mind that allows the recovery process to occur. Some of the findings indicated that the IGM placed an emphasis on the self as opposed to the control of symptoms and dysfunction. The last two internal conditions emerged from the findings, which questions whether the IGM assists in encouraging empowerment, as well as a connection to society and knowledge in their roles and their place within it. Even though the IGM shows elements of these internal conditions, there is limited evidence that it can promote recovery of MHCUs and their healing journey.

Andresen et al. (2006) suggested five stages of recovery. The current study identified that participants found importance in the stage of moratorium and awareness. This occurs when the MHCUs go through a profound sense of loss and hopelessness, but then develop an awareness and realisation that a fulfilling life is possible. The latter three stages, namely preparation, rebuilding, and growth, take an active role in developing recovery skills, and working towards meaningful goals and taking control of their lives. The final stage of growth revolves around living a meaningful life characterised by self-management of illness and a positive sense of self. For

intervention to be recovery-focussed, awareness should be created with opportunity for realisation that a fulfilling life is possible and active preparation and developing skills to rebuild and take control of life should be pursued. Both life and recovery are journeys which are nonlinear, complex, ongoing, and never complete.

5.4.2 Recovery focussed intervention, design and implementation

Designing and implementing a programme that develops and maintains hope, within the mental healthcare landscape, is challenging. Programmes that focus on symptom reduction, hospitalizations and functioning are based on a medical model of mental illness, and are at times in conflict with the consumer-based definitions of recovery, which describe establishing a meaningful life, a positive sense of identity founded on hopefulness and self-determination (Andresen et al., 2003). Person-centred recovery occurs when the person is valued as a social human being and not just a separate entity within a medical framework. This needs to be taken into account as the recovery journey is never complete.

Recovery and occupational therapy means more than just focussing on the here-and-now but looking and planning for a meaningful future within the context of enduring mental health concerns.

Emphasising the importance of this study, Law (1995) stated that client-centred practice in occupational therapy embraces a partnership with people receiving the services. This particular research aimed to provide just that. Law's (1995) definition of client-centred practice assists in understanding how to provide client-centred occupational therapy. This partnership approach to providing therapy and intervention holds a shared approach to treatment. This approach recognises individuals as responsible for their own decision making about their occupational needs. Following this type of approach ensures that treatment is the best fit for the recipient of the intervention within their context. When considering the current study, this is precisely what the intention is. This study was aimed at the consumers themselves, to evaluate whether current intervention was relevant and best suited to their needs.

A key aspect and recommendation when considering recovery is that of the individual in the recovery process. Participants reported that it would have been beneficial for their individual recovery needs to be assessed or communicated at the initiation of the programme. Participants also suggested that they provide the activity ideas as to address these needs. This raises two points. The first point is that the individual within the group, and their recovery process, should still be at the heart of intervention even though the majority of intervention is group based. The second point is that the consumers should drive and always be in control of their recovery process, as they know their needs best.

5.4.3 Occupational therapy, the IGM and client-centred perspective

Fearing and Clarke (2000) said that occupational therapy as a profession claims to reflect a client-centred perspective, therefore intervention, such as groups, should meet the needs of the clients and not be solely reflective of therapist preference and perceived needs of the clients. Bearing this in mind, the IGM with its underlying assumptions around relationships and socialization already assumes the problems and the needs of the clients, and therefore cannot truly be client-centred as an approach in occupational therapy. In a study by Miatra and Erway (2006) it was described that even though occupational therapists perceive themselves as using a client centred-approach, the consumers receiving the intervention did not consistently report feeling like an active participant in their treatment and were unaware of the client-centred approach being used by the treating occupational therapist. This finding was echoed in the findings of the current research where participants voiced that they were just told to engage in groups but were not always clear on the purpose of these groups. Participants questioned the purpose of the groups and the link to recovery. Participants recommended that the programme be planned and displayed so that they could know of the group's content on a particular day in advance, suggesting that they attended the groups without knowledge of the group focus, and engaged in the groups unaware of the purpose. In addition, as part of the recommendations, participants suggested that as consumers, they should be part of the process in choosing which groups and activities were relevant for their needs. This speaks to the fact that the consumers were

not active participants in the intervention process. In this study, the question arose whether the IGM, which is an occupational therapy groupwork model, is occupation or activity focussed and whether recovery could be achieved when groups are not occupation-based. It poses the question whether or not the model is rooted in occupational therapy and the possibility of other professions to utilise it. If occupational therapy claims the model, it should be occupation-based in its focus as this is a key strength and the core of the profession.

The IGM model clearly states that mental illness and mental health concerns are rooted in poor social relationships and therefore at the core of the intervention focus. Recovery of MHCUs requires an individual and holistic focussed approach to intervention. The IGMs narrow intervention focus poses questions on whether it can truly be recovery focussed, when centring intervention in one area or aspect of dysfunction. Occupational therapists view individuals holistically (Watson, 2008) and thus it would be imperative that current practices be re-examined as to ensure that principles and practices align to that of broader policy and legislation. Recovery orientated practice is much more than pharmacological and psychosocial interventions, thus placing collaboratively identified choices and goal setting at the core.

5.5 Revisiting the OTASA position statement on groupwork

Occupational therapy as a profession is experiencing an increasing need to demonstrate its contribution and perceived effectiveness across practice arenas by examining client, carer and therapists views (Wimpenny, Savin-Baden, & Cook, 2014). The groupwork position statement ratified by OTASA raises a number of issues for the profession of occupational therapy.

5.5.1 Activity as means: curtailing the focus of practice

It is acknowledged that a focus on activity as means has been the hallmark of the profession since its inception (Pierce, 2001). However, delimiting the role and scope of groupwork, in occupational therapy to activity based groups only may be detrimental to the growing profession. The OTASA position statement primarily addresses occupational therapy groupwork in private practice mental health clinics rather than occupational therapy groupwork in general. It adopts a medicalised perspective with a focus on patient treatment, which fits in a private medical clinic, however this should be clearly stated in the title and beginning of the position paper. Protecting the territorial nature of groupwork in the private sector where billing is monitored in accordance with professional status and scope of practice, the position statement does not take into account the dire need for groups in the context of limited human resources, and how a range of professions who are trained and competent in groupwork, would assist in building a healthier society. Occupational therapists use groupwork in a variety and wide range of settings based on a wide range of theoretical frameworks with varied participants. While the position statement is useful to delimit the scope of occupational therapy practice in the private sector, it ultimately has the potential to delimit the larger scope of groupwork that occupational therapists are trained to provide. The narrow stance of foregrounding activity as means as opposed to the needs of the occupational human weakens, the position of the profession.

5.5.2 Occupation: expanding the focus of practice

The position paper primarily focusses on one aspect of the occupational human namely social interaction. When therapists decide the focus of therapy, and do not allow the clients to guide their own process, it can potentially hinder their recovery process. As a result, therapy can be inauthentic, unexamined, and an unarticulated practice which can have serious consequences for the recovery of clients and be particularly damaging to the profession (Wimpenny et al., 2014). The alternative is that the position paper be revised to address a much broader perspective ranging from: groupwork as a strategy for disability inclusive development; groupwork as part of occupation-based practice

in development; part of vocational, medical and rehabilitation settings; and, groupwork as part of poverty alleviation initiatives in the labour sector (Kronenberg, Pollard, & Ramugondo (2011). Occupational therapy has great value to add across public sectors. By showcasing the potential and contribution of the full range of occupational therapy groups and what the profession stands for in the national development agenda, it can rightfully claim the value added by an occupational perspective to health, recovery and human well-being (Gillen & Greber, 2014). Other professions such as psychology have theorised performance components and occupational performance and have named it behaviour, however the contribution of occupational therapy is unique in its theorising of human occupation (Wilcock, 2006).

5.5.3 Professional artistry and groupwork

The varied climates in which occupational therapists are required to perform intervention are often hostile and high pressured (Wimpenny et al., 2014). Therapists may feel pressurised to conducted intervention that is delineated and safe to perform within a narrow scope of practice, as is the case with the OTASA position statement. Wimpenny et al. (2014) suggest that professional artistry involves practitioners being willing to embrace error, accept confusion and reflect critically on their previously unexamined assumptions and practices. What are the implications for the profession if therapists comply with the assumptions reflected in the OTASA position statement? Revisiting the OTASA position statement may afford the profession an opportunity to stake its stance on a wide scope of groupwork practice.

5.6 Summary

This chapter highlighted and discussed the key findings of the study. It contrasted the current study with previous research conducted in similar fields. The strengths and weaknesses of the IGM as a groupwork modality were discussed. Recommendations of areas to strengthen, supported by literature were suggested. The complexities of groupwork in mental health and the compatibility of the model to the beliefs of the

occupational therapy profession and recovery-based practice were discussed. The OTASA position statement was revisited with specific comment on the impact of the focus of activity and occupation, as well as professional artistry, on groupwork. The discussion promotes the alignment of policy and practice in a demanding public health sector catering to the needs of the MHCUs. It is argued that mental health services need to allow MHCUs to co-construct their recovery journeys to ensure the relevance thereof.

CHAPTER 6: RECOMMENDATIONS, LIMITATIONS, AND CONCLUSION

6.1 Introduction

This chapter concludes the research report by making recommendations and highlighting the limitations of the study. The purpose of this study was to provide practice based evidence of service user perspectives on occupational therapy groupwork using the IGM in a public sector mental healthcare setting. By taking the disseminated findings into consideration, clinicians who use the IGM will be aligning occupational therapy with current health policy directives regarding person-centred mental health care and evidence-based practice. The findings may also inform future revisions of the OTASA position statement on groupwork.

6.2 Recommendations

These findings provide a basis for practitioners and researchers in mental health to align occupational therapy groupwork practice with the perspectives of MHCUs in the following ways:

6.2.1 Research

When the National Health Insurance policy is implemented in the future it will open up opportunities for public-private sector partnerships in occupational therapy services. It is therefore recommended that research be conducted into the IGM and its use in the private sector mental health occupational therapy practice in South Africa. MHCUs who pay private sector fees may hold different perspectives about their therapy than those who attended Unit X, a public-sector service. Research into the perceptions of therapists on the contribution of the IGM to the recovery of mental health care users could be contrasted with the findings from the perceptions of

MHCUs. Doing such a study would provide greater insight into the use of the model and provide useful information that could be used to refine the IGM.

6.2.2 Practice

Therapists currently using the IGM should consider implementing the recommendations made by the MHCUs in the study. These pertain to:

- The type, range and rotation of activities: The ‘silly’ or ‘childish’ nature of the activity needs should be regularly acknowledged to the group and the purpose of activities that may appear ‘silly’ or ‘childish’ needs to be clarified by explaining the therapeutic rationale behind the selection of activity. An admission to a unit such as Unit X requires users to relinquish meaningful opportunities to engage in self chosen occupations. The range of activities could be increased by drawing on activity and occupations from the MHCUS themselves, for example, cooking as an activity may be a meaningful occupation for some group members. The rotation of activities could be eight weekly to limit the chance of repetition for those that remain on the 12 week programme.
- The duration and frequency of OT groups should be flexible and responsive to the needs of the population. Therapists should provide a therapeutic rationale for the duration and frequency of the IGM groups. Rapid turnover of MHCUs, and the inadequate resourcing of mental health services remain a significant problem in programs. Access to support groups as part of community based mental health services which run according to the principles of IGM may assist in increasing access, and therefore the duration and frequency of the groups.
- The variation in group setting: This can range from a change of rooms for different types of activities, to using outside areas as well as particular groups being run offsite, should the institution allow it.
- The obtaining and implementing feedback and suggestions from group members: Clinicians should develop an evaluation of the OT service, and

encourage each MHCUs to complete this as part of their discharge process in an effort to ensure services are relevant to the changing needs of the clients.

- The provision of individual OT sessions at the beginning of each MHCU's intervention to ensure that the needs and goals of the MHCUs are obtained and clarified by the service users themselves.
- Differentiating between activity and occupation: Though closely interlinked, the concepts are fundamentally different. The main consideration is that a person's context and subjectivity as a performer of a range of roles need to be taken into consideration when considering the scope of occupations that he or she may find enhancing or compromising health and recovery.

6.2.3 Policy

The OTASA position statement reflects a narrow range of practice, therefore delineating instead of broadening the scope of groupwork interventions that occupational therapists are competent to deliver. It is suggested that OTASA revisit the position statement on groupwork by considering whether a broader version could be developed that represents all facets of occupational therapy groupwork, ranging from small groups using therapeutic activity to intrapsychic groups using evocative techniques to large groups in community settings. The position statements on groupwork in occupational therapy would remain sensitive to the differences between the public and private sector, and in doing so strengthen the profession.

It is also recommended that occupational therapists continue to align their services with National Department of Health imperatives of consumer participation during the development and implementation of intervention. Though the need is recognised, it is not always carried into practice. Service users should be considered and consulted before intervention is implemented and the frequency of service evaluation by consumers needs to be increased.

6.3 Limitations

The participant used for the pilot study to fine tune the interview schedule was diagnosed with mild intellectual impairment. This diagnosis was confirmed after minor changes were made to the interview schedule. At this time, other participants had already been recruited for the research and had commenced with their first interview. Had an effective pilot study been conducted, the research may have had the potential to be richer and have greater depth.

Not all of the participants were able to participate in all 3 interviews. A number were not contactable after discharge as well as two participants only being interviewed once due to a prolonged admission. The quality of the data about the contribution of IGM groups to recovery would have been richer if more opportunity existed for participants to share their post discharge reflections. No males were included in the study as the men who had been admitted to Unit X during the study period did not fit the inclusion criteria. This could potentially have affected the depth of the findings. Unit X is a therapeutic unit which does not admit psychotic disorders. These disorders account for a significant constituent of the burden of care in mental health. The population sampled was therefore not representative of the South African mental health community.

Data analysis yielded one theme which could have affected the depth of the study. Had more data been collected during the research process, existing categories may have been able to stand as themes.

The research took place at one institution, and therefore findings cannot be generalised to the broader population. However, a great deal can still be learnt from the study and the findings used to enhance use of IGM in OT mental health practice.

6.4 Conclusion

The purpose of this study was to provide practice-based evidence of service user perspectives on occupational therapy groupwork using the IGM in a public sector

mental healthcare setting. By taking the disseminated findings into consideration, clinicians who use the IGM will be aligning occupational therapy with current health policy directives regarding person-centred mental health care (Western Cape Government Health, 2014) and evidence based practice. The findings may also inform future revisions of the OTASA position statement on groupwork.

Research confirms that engagement in occupation is vital for the recovery journey of mental health care users (Boniface, Humpage, Awatar, & Reagon, 2015; Kelly et al., 2010; Wiseman & Sadlo, 2015). Whether or not the IGM provides sufficient space for occupation to occur, remains in question. The IGM is beneficial as a change modality because it helps MHCUs to learn about themselves while relating to others. When using activity as means, it addresses the interpersonal aspect of recovery during the acute intervention phase. It is effective in helping MHCUs to learn that a more positive life is possible. The relevance of the IGM to the post-discharge recovery of MHCUs warrants attention if occupational therapy is to play a role in supporting MHCUs to live meaningful and productive lives through occupation. Recovery from serious mental illness is a complex lifelong process that is facilitated when health care professionals collaborate with MHCUs in coping with practical daily living challenges, most of which involve much more than problems with interpersonal skills. The findings suggest that the IGM has therapeutic value to offer those experiencing acute mental health concerns by helping them gain better self-awareness about interpersonal relationships. If refined and taking into account the occupational human, and embracing the recovery philosophy, the IGM may offer greater value to MHCUs by addressing broader occupational engagement concerns. Even though this model has relevance to improving interpersonal aspects of mental health, its potential may be extended to promote post-discharge recovery of MHCUs. Therefore, OTASA needs to ensure that its position statement on groupwork represents the total sphere and understanding of groupwork in the profession, or groupwork in mental health. position statement would require refinement or clear delineation to clearly state the area of practice it represents. Thus, expanding the profession's focus from activity as means to occupation in context could enrich the IGM as well as OTASA position statement on groupwork.

REFERENCES

- Aceves-Gonzalez, C., Cook, S., & May, A. (2014). Inclusive service design: In search of better services. *Advances in Ergonomics In Design, Usability & Special Populations. Part III*, (July), 10–19. Retrieved from <https://dspace.lboro.ac.uk/2134/17581>
- American Occupational Therapy Association. (2014). *Occupational Therapy Practice Framework: Domain and Process. American Journal of Occupational Therapy* (2nd ed., Vol. 68). American Occupational Therapy Association. Retrieved from <http://dx.doi.org/10.5014/ajot.2014.682006>
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders : DSM-IV*. Virginia: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders : DSM-5*. Washington: American Psychiatric Association.
- Andreasen, N. C., Carpenter, W. T., Kane, J. M., Lasser, R. A., Marder, S. R., & Weinberger, D. R. (2005, March 1). Remission in schizophrenia: Proposed criteria and rationale for consensus. *American Journal of Psychiatry*. American Psychiatric Publishing. <https://doi.org/10.1176/appi.ajp.162.3.441>
- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically-validated stage model., *37*(5), 586–594.
- Arbesman, M., & Logsdon, D. W. (2011). Occupational therapy interventions for employment and education for adults with serious mental illness: A systematic review. *American Journal of Occupational Therapy*, *65*(3), 238–246. <https://doi.org/10.5014/ajot.2011.001289>
- Babyak, M., Blumenthal, J. A., Herman, S., Khatry, P., Doraiswamy, M., Moore, K., ... Krishnan, A. K. R. (2000). Exercise Treatment for Major Depression: Maintenance of Therapeutic Benefit at 10 Months. *Psychosomatic Medicine*, *62*(21), 633–638. <https://doi.org/00006842-200009000-00006>
- Barker, P. (2001). The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, *8*(3), 233–240. <https://doi.org/10.1046/j.1365-2850.2001.00391.x>
- Barnes, B., Ernst, S., & Hyde, K. (1999). *An introduction to groupwork: a group analytic perspective*. London: Macmillan.
- Baxter, P., & Jack, S. (2008). The qualitative report qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, *13*(4), 544–599. <https://doi.org/citeulike-article-id:6670384>
- Bell, T., Uwc, B., Up, M., Wegner, L., Blake, L., Uwc, O. T., ... Uwc, O. T. (2015). Clients ' perceptions of an occupational therapy intervention at a substance use rehabilitation centre in the Western Cape Study design, *45*(2), 10–14.
- Benatar, S. R. (2013). The challenges of health disparities in South Africa. *South African Medical Journal*, *103*(3), 154. <https://doi.org/10.7196/SAMJ.6622>
- Bird, P., Omar, M., Doku, V., Lund, C., Nsereko, J. R., Mwanza, J., & MHaPP Research Programme Consortium. (2011). Increasing the priority of mental health in Africa: findings from qualitative research in Ghana, South Africa, Uganda and Zambia. *Health Policy and Planning*, *26*(5), 357–365. <https://doi.org/10.1093/heapol/czq078>
- Blackmore, C., Wong, R., & Johnson, M. (2009). *A systematic review of the efficacy and clinical effectiveness of group analysis and analytic/dynamic group*

- psychotherapy. *ScHARR*. Retrieved from https://www.sheffield.ac.uk/polopoly_fs/1.120473!/file/IGA_GAS_FINAL_REPORT.pdf
- Boddy, C. R. (2016). Qualitative Market Research: An International Journal Sample size for qualitative research. *Qualitative Market Research: An International Journal An International Journal Iss Management Decision*, 19(4), 426–432. Retrieved from <https://doi.org/10.1108/QMR-06-2016-0053>
- Boniface, G., Humpage, S., Awatar, S., & Reagon, C. (2015). Developing an occupation- and recovery-based outcome measure for people with mental health conditions: An action research study. *British Journal of Occupational Therapy*, 78(4), 222–231. <https://doi.org/10.1177/0308022614562788>
- Bowers, L., & PhD, R. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21(6), 499–508. <https://doi.org/10.1111/jpm.12129>
- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006, January). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*. <https://doi.org/10.1016/j.cpr.2005.07.003>
- Carpenter, J. (2002). Mental Health Recovery Paradigm: Implications for Social Work. *Health & Social Work*, 27(2), 86–94. <https://doi.org/10.1093/hsw/27.2.86>
- Caruso, R., Grassi, L., Biancosino, B., Marmai, L., Bonatti, L., Moscara, M., ... Priebe, S. (2013). Exploration of experiences in therapeutic groups for patients with severe mental illness: Development of the Ferrara group experiences scale (FE- GES). *BMC Psychiatry*, 13(1), 1. <https://doi.org/10.1186/1471-244X-13-242>
- Charmaz, K. (2014). *Constructing grounded theory* (Second). Thousand Oaks, CA: SAGE.
- Chlup, D. T., & Collins, T. E. (n.d.). Breaking the Ice: Using Ice- breakers and Re-energizers with Adult Learners. Retrieved from <http://journals.sagepub.com.ezproxy.uct.ac.za/doi/pdf/10.1177/104515951002100305>
- Cole, M. B. (2012). *Group dynamics in occupational therapy : the theoretical basis and practice application of group intervention* (Fourth). NJ: Slack.
- Cole, M. B. (2014). Client-centred groups. In W. Bryant, J. Fieldhouse, K. Bannigan, J. Creek, & L. Lougher (Eds.), *Creek's Occupational Therapy and Mental Health* (5th ed., p. 502). Oxford: Churchill Livingstone/Elsevier.
- Cowls, J., & Hale, S. (2005). It's the activity that counts: What clients value in psycho-educational groups. *Canadian Journal of Occupational Therapy*, 72, 176–182. <https://doi.org/10.1177/000841740507200305>
- Creswell, J. W. (2007). Chapter 3: Designing a Qualitative Study. In *Qualitative inquiry and research design: Choosing among five approaches* (Second, pp. 35–41). SAGE PublicationsSage UK: London, England. <https://doi.org/10.1080/0957514810010204>
- Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in Serious Mental Illness: A New Wine or Just a New Bottle? *Professional Psychology: Research and Practice*, 36(5), 480–487. <https://doi.org/10.1037/0735-7028.36.5.480>
- Dennis Persson, L.-K. E. (2001). Value Dimensions, Meaning, and Complexity in Human Occupation - A Tentative Structure for Analysis. *Scandinavian Journal of Occupational Therapy*, 8(1), 7–18. <https://doi.org/10.1080/11038120119727>

- Dierick, P., & Lietaer, G. (2008). Client Perception of Therapeutic Factors in Group Psychotherapy and Growth Groups: An Empirically-Based Hierarchical Model. *International Journal of Group Psychotherapy*, 58(2), 203–230. <https://doi.org/10.1521/ijgp.2008.58.2.203>
- Drum, D., Swanbrow Becker, M., & Hess, E. (2011). Expanding the Application of Group Interventions: Emergence of Groups in Health Care Settings. *Journal for Specialists in Group Work*, 36(4), 247–263. <https://doi.org/10.1080/01933922.2011.613902>
- Eklund, M., & Bäckström, M. (2006). The role of perceived control for the perception of health by patients with persistent mental illness. *Scandinavian Journal of Occupational Therapy*, 13(4), 249–256. <https://doi.org/10.1080/11038120600928823>
- Farkas, M. (2007). The vision of recovery today: what it is and what it means for services. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, 6(2), 68–74. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2219905&tool=pmc&entrez&rendertype=abstract>
- Fearing, V. G., & Clark, J. (2000). *Individuals in context : a practical guide to client-centered practice*. New Jersey: Slack.
- Finlay, L. (2004). *The Practice of Psychosocial Occupational Therapy*. Nelson Thornes. Retrieved from https://books.google.co.za/books/about/The_Practice_of_Psychosocial_Occupational.html?id=m7SnGfSxfaYC&redir_esc=y
- Fisher, D. B. (1994). A new vision of healing as constructed by people with psychiatric disabilities working as mental health providers. *Psychosocial Rehabilitation Journal*, 17(3), 67–81. <https://doi.org/10.1037/h0095574>
- Funk, M., Van Ommeren, M., Mental Health and Poverty Project., & World Health Organization. (2010). *Mental health and development : targeting people with mental health conditions as a vulnerable group*. World Health Organization.
- Geppert, C. M. A., & Abbott, C. (2007). Voluntarism in consultation psychiatry: the forgotten capacity. *The American Journal of Psychiatry*, 164(3), 409–13. <https://doi.org/10.1176/ajp.2007.164.3.409>
- Gibson, D. (1988). *Group process and structure in psychosocial occupational therapy*. Haworth Press. Retrieved from https://books.google.co.za/books?id=US_KAgAAQBAJ&dq=A+group+is+defined+as+an+aggregate+of+people+who+share+a+common+purpose,+which+can+be+obtained+only+by+group+members+interacting+and+working+together
- Gillen, A., & Greber, C. (2014). Occupation-Focused Practice: Challenges and Choices. *British Journal of Occupational Therapy*, 77(1), 39–41. <https://doi.org/10.4276/030802214X13887685335580>
- Gray, J. M. (1998). Putting Occupation Into Practice: Occupation as Ends, Occupation as Means. *American Journal of Occupational Therapy*, 52(5), 354–364. <https://doi.org/10.5014/ajot.52.5.354>
- Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits. *Journal of Psychosomatic Research*, 57(1), 35–43. [https://doi.org/10.1016/S0022-3999\(03\)00573-7](https://doi.org/10.1016/S0022-3999(03)00573-7)
- Harvey, C., Brophy, L., Parsons, S., Moeller-Saxone, K., Grigg, M., & Siskind, D. (2016). People living with psychosocial disability: Rehabilitation and recovery-informed service provision within the second Australian national survey of psychosis. *Australian & New Zealand Journal of Psychiatry*, 50(6), 534–547.

<https://doi.org/10.1177/0004867415610437>

- Hassan, G. (2013). Groupthink principles and fundamentals in organizations. *Interdisciplinary Journal of Contemporary Research in Business*, 5(8), 225–240. Retrieved from <http://journal-archives36.webs.com/225-240dec.pdf>
- Howe, M. C., & Schwartzberg, S. L. (2001). *A functional approach to group work in occupational therapy* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.
- Ikiugu, M. N., Hoyme, A. K., Mueller, B. A., & Reinke, R. R. (2015). Meaningful occupation clarified: Thoughts about the relationship between meaningful and psychologically rewarding occupations. *South African Journal of Occupational Therapy*, 45(1), 47–50. <https://doi.org/10.17159/2310-3833/2015/v45no1a8>
- INTERACTIVE GROUPWORK MODEL notes (1). (n.d.).
- Jack, H., Wagner, R., & Petersen, I. (2014). Closing the mental health treatment gap in South Africa: a review of costs and cost-effectiveness. *Global Health ...*, 1, 1–11. Retrieved from <http://go.galegroup.com/ps/i.do?p=AONE&u=27uos&id=GALE%7CA385714366&v=2.1&it=r&sid=AONE&asid=65bfd614>
- Jacob, K. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. *Indian Journal of Psychological Medicine*, 37(2), 117–119. <https://doi.org/10.4103/0253-7176.155605>
- Jacobson, N., & Greenley, D. (2001). What Is Recovery ? A Conceptual Model and Explication. *Psychiatric Services*, 52(4), 482–485. <https://doi.org/10.1176/appi.ps.52.4.482>
- Jhanjee, S. (2014). Evidence based psychosocial interventions in substance use. *Indian Journal of Psychological Medicine*, 36(2), 112–8. <https://doi.org/10.4103/0253-7176.130960>
- Jose, J. P., Cherayi, S., & Sadath, A. (2016). Conceptualizing Psychosocial Disability in Social Exclusion: A Preliminary Discourse. *Contemporary Voice of Dalit*, 8(1), 1–13. <https://doi.org/10.1177/2455328X16628770>
- Kelly, M., Lamont, S., & Brunero, S. (2010). An occupational perspective of the recovery journey in mental health. *British Journal of Occupational Therapy*, 73(3), 129–135. <https://doi.org/10.4276/030802210X12682330090532>
- Kleintjes, S., Lund, C., & Swartz, L. (2013). Barriers to the participation of people with psychosocial disability in mental health policy development in South Africa: a qualitative study of perspectives of policy makers, professionals, religious leaders and academics. *BMC International Health and Human Rights*, 13(1), 17. <https://doi.org/10.1186/1472-698X-13-17>
- Koukourikos, K., & Pasmatzi, E. (2014). Group therapy in psychotic inpatients. *Health Science Journal*, 8(3), 400–408. Retrieved from <http://www.hsj.gr/medicine/group-therapy-in-psychotic-inpatients.pdf>
- Law, M., Baptiste, S., & Mills, J. (1995). Client-Centred Practice: What does it Mean and Does it Make a Difference? *Canadian Journal of Occupational Therapy*, 62(5), 250–257. <https://doi.org/10.1177/000841749506200504>
- Lieberman, N., & Trope, Y. (2008). The psychology of transcending the here and now. *Science (New York, N.Y.)*, 322(5905), 1201–5. <https://doi.org/10.1126/science.1161958>
- Lietaer, G., & Dierick, P. (2015). Client perception of hindering factors in group psychotherapy and growth groups: no growth without pain? An empirical exploration. *Person-Centered and Experiential Psychotherapies*, 14(1), 62–82. <https://doi.org/10.1080/14779757.2014.991938>
- Lim, K. H., Morris, J., & Craik, C. (2007). Inpatients' perspectives of occupational

- therapy in acute mental health. *Australian Occupational Therapy Journal*, 54(1), 22–32. <https://doi.org/10.1111/j.1440-1630.2006.00647.x>
- Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. California: Sage Publications.
- Lincoln, Y., & Guba, E. (1994). Paradigmatic controversies, contradictions, and emerging confluences. In *Handbook of qualitative research* (p. 643). https://doi.org/10.1111/j.1365-2648.2005.03538_2.x
- Lund, C. (2012). Poverty and mental health: a review of practice and policies. *Neuropsychiatry*, 2(3), 213–219. <https://doi.org/10.2217/npv.12.24>
- Lund, C., Kleintjes, S., Kakuma, R., Flisher, A. J., & Consortium, the Mh. R. P. (2010). Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications. *Social Psychiatry and Psychiatric Epidemiology*, 45(3), 393–404. <https://doi.org/10.1007/s00127-009-0078-5>
- Lunenburg, F. C. (2010). Group decision making: the potential for groupthink. *Int. J. of Management, Business and Administration*, 13(1), 1–6. Retrieved from <https://pdfs.semanticscholar.org/c7b2/4288a1368739011f3f68a478dd48489e4733.pdf>
- Macnair-Semands, R. R., & Lese, K. P. (2000). Interpersonal problems and the perception of therapeutic factors in group therapy. *Small Group Research*, 31(2), 158–174. <https://doi.org/10.1177/104649640003100202>
- Maitra, K. K., & Erway, F. (2006). Perception of client-centered practice in occupational therapists and their client. *The American Journal of Occupational Therapy*, 298–310. <https://doi.org/10.5014/ajot.60.3.298>
- Matsoso, M. P., & Fryatt, R. (2013). National Health Insurance: The first 18 months. *South African Medical Journal*, 103(3), 156. <https://doi.org/10.7196/SAMJ.6601>
- McCarthy, C. J., & Hart, S. (2011). Designing Groups to Meet Evolving Challenges in Health Care Settings. *Journal for Specialists in Group Work*, 36(4), 352–367. <https://doi.org/10.1080/01933922.2011.614143>
- Mental Health America. (2015). Position Statement 11: In Support of Recovery-Based Systems Transformation | Mental Health America. Retrieved January 3, 2018, from http://www.mentalhealthamerica.net/positions/recovery-systems#_edn1
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods*, 1(2), 13–22. <https://doi.org/10.1177/160940690200100202>
- Mosey, A. C. (1981). *Occupational therapy: configuration of a profession*. New York, N.Y.: Raven Press.
- Mroz, T. M., Pitonyak, J. S., Fogelberg, D., & Leland, N. E. (2015). Client Centeredness and Health Reform: Key Issues for Occupational Therapy. *American Journal of Occupational Therapy*, 69(5), 6905090010p1. <https://doi.org/10.5014/ajot.2015.695001>
- Munhall, P. L. (2012). Perception In: The SAGE Encyclopedia of Qualitative Research Methods. <https://doi.org/10.4135/9781412963909>
- Nakamura, J., & Csikszentmihalyi, M. (2009). *Flow Theory and Research*. Oxford handbook of positive psychology. New York, N.Y.: Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780195187243.013.0018>
- National Department of Health (South Africa). (2013). National Mental Health Policy Framework and Strategic Plan: 2013-2020. Retrieved January 2, 2018, from <https://www.health-e.org.za/wp-content/uploads/2014/10/National->

- Mental-Health-Policy-Framework-and-Strategic-Plan-2013-2020.pdf
National Department of Health (South Africa). (2015). *National Health Insurance for South Africa: Towards Universal Health Coverage. White Paper* (Vol. 48). Retrieved from <https://www.health-e.org.za/wp-content/uploads/2015/12/National-Health-Insurance-for-South-Africa-White-Paper.pdf>
- Northen, H., & Kurland, R. (2013). *Social Work with Groups*. New York, N.Y.: Columbia University Press. Retrieved from https://books.google.co.za/books/about/Social_Work_with_Groups.html?id=SW0slEfHqS0C&redir_esc=y
- Nugent, A., Hancock, N., & Honey, A. (2017). Developing and Sustaining Recovery-Orientation in Mental Health Practice: Experiences of Occupational Therapists. *Occupational Therapy International*, 2017, 1–9. <https://doi.org/10.1155/2017/5190901>
- Occupational Therapy Association of South Africa. (2014). Position statement on therapeutic group work in Occupational Therapy. *South African Journal of Occupational Therapy*, 44(3), 43–44. Retrieved from <http://www.otasa.org.za/documents/GoupworkPositionPaperRatified-by-Council-for-OTASA-Website.pdf>
- Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. *The Qualitative Report*, 13(4), 695–705. Retrieved from <http://nsuworks.nova.edu/tqr>
- Parker, J. (2014). Recovery in mental health. *South African Medical Journal*, 104(1), 77. <https://doi.org/10.7196/SAMJ.7732>
- Parry, C. D. (2015). SUBSTANCE ABUSE IN SOUTH AFRICA: COUNTRY REPORT, 1(February), 24–26.
- Pierce, D. (2001). Untangling occupation and activity. *American Journal of Occupational Therapy*, 55(2), 138–146. <https://doi.org/10.5014/ajot.55.2.138>
- Pöllänen, S. H. (2015). Crafts as Leisure-Based Coping: Craft Makers' Descriptions of Their Stress-Reducing Activity. *Occupational Therapy in Mental Health*, 31(2), 83–100. <https://doi.org/10.1080/0164212X.2015.1024377>
- Pollard, N., & Cook, S. (2012). The power of low-key groupwork activities in mental health support work, 22(223), 7–327. <https://doi.org/10.1921/095182412X662167>
- Rispel, L., Moorman, J., Chersich, M., Goudge, J., Nxumalo, N., & Ndou, T. (2010). *Revitalising Primary Health Care in South Africa: Review of primary health care package, norms and standards*. Johannesburg.
- Rose, J. D. (2011). Diverse Perspectives on the Groupthink Theory – A Literary Review. *Emerging Leadership Journeys*, 4(c), 37–57. Retrieved from http://www.dentonisd.org/cms/lib/TX21000245/Centricity/Domain/5139/groupthink_article.pdf
- Rosner, R., Lumbeck, G., & Geissner, E. (2011). Effectiveness of an inpatient group therapy for comorbid complicated grief disorder. *Psychotherapy Research*, 2(21), 210–2018. <https://doi.org/10.1080/10503307.2010.545839>
- Rutan, J. S., Stone, W. N., & Shay, J. J. (2014). *Psychodynamic Group Psychotherapy*. Guilford Press (4th ed.). Guilford Publications. Retrieved from <https://www.guilford.com/books/Psychodynamic-Group-Psychotherapy/Rutan-Stone-Shay/9781462516506/reviews>
- Sampson, E. E., & Marthas, M. S. (1981). *Group process for the health professions*. New York, N.Y.: Wiley.

- Slade, M. (2010). Mental illness and well-being: The central importance of positive psychology and recovery approaches. *BMC Health Services Research*, 10(1), 26. <https://doi.org/10.1186/1472-6963-10-26>
- Smith, L. J. (2008). How ethical is ethical research? Recruiting marginalized, vulnerable groups into health services research. *Journal of Advanced Nursing*, 62(2), 248–257. <https://doi.org/10.1111/j.1365-2648.2007.04567.x>
- Spaniol, L. (2009). What Would a Recovery-Oriented Program Look Like? Retrieved December 29, 2017, from http://www.psychosocial.com/IJPR_13/Recovery_Oriented_Program_Spaniol.html
- Srivastava, A., & Thompson, B. (2009). Framework analysis: a qualitative methodology for applied policy research. *Joaag*, 4(2), 72–79. <https://doi.org/10.7748/nr2011.01.18.2.52.c8284>
- Sundsteigen, B., Eklund, K., & Dahlin-Ivanoff, S. (2009). Patients' experience of groups in outpatient mental health services and its significance for daily occupations. *Scandinavian Journal of Occupational Therapy*, 16(3), 172–180. <https://doi.org/10.1080/11038120802512433>
- Thimm, J. C., & Antonsen, L. (2014). Effectiveness of cognitive behavioral group therapy for depression in routine practice. *BMC Psychiatry*, 14, 292. <https://doi.org/10.1186/s12888-014-0292-x>
- Townsend, E., Stanton, S., Law, M., Polatajko, H., & Baptiste, S. (2002). Enabling Occupation: An Occupational Therapy Perspective. *Caot*, XVI, 210 s.
- Trombly, C. A. (1995). Occupation: Purposefulness and Meaningfulness as Therapeutic Mechanisms. *American Journal of Occupational Therapy*, 49(April), 960–972.
- Vaismoradi, M., Turunen, H., & Bondas, T. (2013, September 1). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*. <https://doi.org/10.1111/nhs.12048>
- van Knippenberg, D., Haslam, S. A., & Platow, M. J. (2007). Unity through diversity: Value-in-diversity beliefs, work group diversity, and group identification. *Group Dynamics: Theory, Research, and Practice*, 11(3), 207–222. <https://doi.org/10.1037/1089-2699.11.3.207>
- Van Teijlingen, E. R., Rennie, A. M., Hundley, V., & Graham, W. (2001). The importance of conducting and reporting pilot studies: the example of the Scottish Births Survey. *Journal of Advanced Nursing*, 34(3), 289–95. <https://doi.org/10.1046/j.1365-2648.2001.01757.x>
- Waghorn, G., Lloyd, C., & Clune, A. (2009). Reviewing the Theory and Practice of Occupational Therapy in Mental Health Rehabilitation. *British Journal of Occupational Therapy*, 72(7), 314–323. <https://doi.org/10.1177/030802260907200708>
- Western Cape Government Health. (2014). Healthcare 2030: The road to wellness, 2–38. <https://doi.org/10.1016/j.ajodo.2005.02.022>
- WFOT. (2013). Definitions of occupational therapy from member organizations. *World Federation of Occupational Therapists*, 2013(2012), 49.
- WFOT. (2017). WFOT | About Us | Occupational Therapy | Definition of Occupational Therapy. Retrieved January 5, 2018, from <http://www.wfot.org/AboutUs/AboutOccupationalTherapy/DefinitionofOccupationalTherapy.aspx>
- Whalley Hammell, K. R. (2013). Client-centred practice in occupational therapy: Critical reflections. *Scandinavian Journal of Occupational Therapy*, 20(3),

- 174–181. <https://doi.org/10.3109/11038128.2012.752032>
- Whalley Hammell, K. R. (2015). Client-centred occupational therapy: The importance of critical perspectives. *Scandinavian Journal of Occupational Therapy*, 22(4), 237–243. <https://doi.org/10.3109/11038128.2015.1004103>
- Wilcock, A. A. (1999). Reflections on doing, being and becoming. *Australian Occupational Therapy Journal*, 46(1), 1–11. <https://doi.org/10.1046/j.1440-1630.1999.00174.x>
- Wilcock, A. A. (2006). *An occupational perspective of health*. New Jersey: SLACK. Retrieved from https://books.google.co.za/books/about/An_Occupational_Perspective_of_Health.html?id=voKCHG3xL70C&redir_esc=y
- Wimpenny, K., Savin-Baden, M., & Cook, C. (2014). A qualitative research synthesis examining the effectiveness of interventions used by occupational therapists in mental health. *British Journal of Occupational Therapy*, 77(66), 276–288. <https://doi.org/10.4276/030802214X14018723137959>
- Wiseman, T., & Sadlo, G. (2015). Gardening: An occupation for recovery and wellness. In *International Handbook of Occupational Therapy Interventions, Second Edition* (pp. 797–809). Cham: Springer International Publishing. https://doi.org/10.1007/978-3-319-08141-0_58
- World Health Organization. (2011). 1. World Report on Disability. *WHO*. World Health Organization. Retrieved from http://www.who.int/disabilities/world_report/2011/en/
- World Health Organization. (2014). WHO | Mental health: a state of well-being. Retrieved December 19, 2017, from http://www.who.int/features/factfiles/mental_health/en/
- World Health Organization. (2016). Framework on integrated, people-centred health services. *World Health Assembly*, (A69/39), 1–12. <https://doi.org/10.1111/igs.13866>
- Yalom, I. D. (1975). *The theory and practice of group psychotherapy* (2nd ed.). New York, N.Y.: BasicBooks.
- Yalom, I. D. (2005). *The theory and practice of group psychotherapy*. <https://doi.org/0465092845>

APPENDICES

Appendix A : OTASA position statement on groupwork

5. Chiò A, Cocito D, Leone M, Giordana MT, Mora G, Mutani R, Piemonte and Valle d'Aosta register for Guillain-Barré Syndrome. Guillain-Barré Syndrome: A prospective, population-based incidence and outcome survey. *Neurology*, 2003; 60(7): 1146-1150.
6. McClellan K, Armeau E, Parish T. Recognizing Guillain-Barré Syndrome in the Primary Care Setting. *The Internet Journal of Allied Health Sciences and Practice*, 2007; 5(1):1-8.
7. Gonzalez-Suarez I, Sanz-Gallego I, de Rivera FJR, Arpa J. Guillain-Barre syndrome: Natural history and prognostic factors: A retrospective review of 106 cases. *BMC Neurology*, 2013; 13(95):1-6.
8. Govoni V, Granieri E. Epidemiology of the Guillain-Barré Syndrome. *Current Opinion in Neurology*, 2001; 14(5): 605-613.
9. Rajabally YA, Uncini A. Outcome and its predictors in Guillain-Barre syndrome. *Journal of Neurology, Neurosurgery and Psychiatry*, 2012; 83: 711-718.
10. Sulton LL. A multidisciplinary care approach to Guillain-Barré Syndrome. *Dimensions of Critical Care Nursing*, 2001; 20(1): 16-22.
11. Klein K, Boals A. The relationship of life event stress and working memory capacity. *Applied Cognitive Psychology*, 2001; 15(5): 565-579.
12. Shors TJ. Stressful experience and learning across the lifespan. *The Annual Review of Psychology*, 2006; 57: 55-85.
13. Blanco K, Cuomo N. From the other side of the bedrail: A personal experience with Guillain-Barré Syndrome. *Journal of Neurosurgical Nursing*, 1983; 15(6): 355-359.
14. Vargo JW. On counselling the physically disabled. *Canadian Journal of Counselling and Psychotherapy*, 2012; 13(1): 14-17.
15. Hirschberger G, Florian V, Mikulincer M. Fear and compassion: A terror management analysis of emotional reactions to physical disability. *Rehabilitation Psychology*, 2005; 50(3): 246-257.
16. American Occupational Therapy Association. Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy*, 2002; 56(6): 609-639.
17. Koenig HG, Larson DB, Larson SS. Religion and coping with serious medical illness. *Annals of Pharmacotherapy*, 2001; 35(3): 352-359.
18. Hughes RAC, Wijidicks EFM, Benson E, et al. Supportive care for patients with Guillain-Barré Syndrome. *Archives of Neurology*, 2005; 62(8): 1194-1198.
19. Benditt JO. The neuromuscular respiratory system: physiology, pathophysiology, and a respiratory care approach to patients. *Respiratory Care*, 2006; 51(8): 829-837.
20. Laghi F, Tobin MJ. Disorders of the respiratory muscles. *American Journal of Respiratory and Critical Care Medicine*, 2003; 168(1): 10-48.
21. Forwell SJ, Copperman LF, Hugos L. Chapter 40: Neurodegenerative diseases. In Radomski MV, Trombly Latham CA (eds.). *Occupational Therapy for Physical Dysfunction*. 6th ed. Philadelphia: Lippincott, Williams & Wilkins, 2008.
22. Fan E. What is stopping us from early mobility in the intensive care unit? *Critical Care Medicine*, 2010; 38(11): 2254-2255.
23. Schweickert WD, Pohlman MC, Pohlman AS, Nigos C, Pawlik AJ, Esbrook CL, Spears L, Miller M, Franczyk M, Deprizio D, Schmidt GA, Bowman A, Barr R, McCallister KE, Hall JB, Kress JR Early physical and occupational therapy in mechanically ventilated, critically ill patients: a randomised control trial. *Lancet*, 2009; 373(9678): 1874-1882.
24. Chaudhuri A, Behan PO. Fatigue in neurological disorders. *Lancet*, 2004; 363(9413): 978-988.
25. Garssen MPJ, Bussmann JBJ, Schmitz PIM, Zandbergen A, Welter TG, Merkies ISJ, Stam HJ, van Doorn PA. Physical training and fatigue, fitness, and quality of life in Guillain-Barre Syndrome and CIDP. *Neurology*, 2004; 63(12): 2393-2395.
26. Du Toit V. *Patient volition and action in occupational therapy*. 4th ed. Pretoria: The Vona and Marie du Toit Foundation, 2009.
27. Kielhofner G. *Conceptual foundations of occupational therapy*. 2nd ed. Philadelphia: FA Davis, 1997.
28. Kielhofner G. *Model of Human Occupation: Theory and Application*. 4th ed. Philadelphia: Lippincott, Williams & Wilkins, 2008.
29. Hinojosa J, Kramer P. Statement – Fundamental concepts of occupational therapy: Occupation, purposeful activity, and function. *American Journal of Occupational Therapy*, 1997; 51(10): 864-866.
30. Guidetti S, Tham K. Therapeutic strategies used by occupational therapists in self-care training: A qualitative study. *Occupational Therapy International*, 2002; 9(4): 257-276.
31. Law M, Cooper BA, Strong S, Stewart D, Rigby P, Letts L. The Person-Environment-Occupation Model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy*, 1996; 63(1): 9-23.
32. Baker SM, Marshak HH, Rice GT, Zimmerman GJ. Patient participation in physical therapy goal setting. *Physical Therapy*, 2001; 81(5): 1118-1126.
33. Baum CM, Law M. Occupational therapy practice: Focussing on occupational performance. *American Journal of Occupational Therapy*, 1997; 51(4) 277-288.
34. Donnelley C, Carswell A. Individualized outcome measures: A review of the literature. *Canadian Journal of Occupational Therapy*, 2002; 69(2):84-94.
35. Foster M. Skills for practice. In Turner A, Foster M, Johnson SE (eds.). *Occupational therapy and physical dysfunction: Principles, skills and practice*. 5th ed. London: Churchill Livingstone, 2002.
36. Royal E, Reynolds FA, Houlden H. What are the experiences of adults returning to work following recovery from Guillain-Barre syndrome? An interpretive phenomenological analysis. *Disability and Rehabilitation*, 2009; 31(22): 1817-1827.

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POSITION PAPER

Position statement on therapeutic group-work in occupational therapy Occupational Therapy Association of South Africa (OTASA)

I. INTRODUCTORY STATEMENT OF THE PURPOSE OF THE PAPER

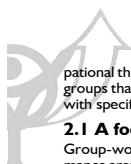
The purpose of this paper is to state OTASA's position on the way occupation-focused group-work relates to occupational therapy's scope of practice, with particular attention to mental health care. The position paper however still holds relevance for other areas of practice in the profession. The paper further serves to guide occupational therapists to define, plan, present and evaluate their groups. This statement however, does not preclude the use of other complementary frames of reference typically used in group therapy

in addition to an occupation-focused framework, for example developmental and psychodynamic approaches.

2. STATEMENT OF THE POSITION BEING TAKEN

The Occupational Therapy Association of South Africa (OTASA) affirms that occupational therapists are experts in the use of occupation as both a means and an end in facilitating health, and promoting participation in meaningful life roles. Occupation thus forms an integral part of occupational therapy group-work in all areas of occu-





pational therapy practice. The four criteria for occupation-focused groups that have emerged from occupational therapy group-work with specific reference to mental health-care practice are:

2.1 A focus on occupation

Group-work should address dysfunctional occupational performance area(s). In a mental health care setting, social participation is often problematic, impacting occupational performance areas such as play, schooling and work. The occupational therapist facilitates the group in such a way that each group member's poor social skills and impaired ability to build healthy interpersonal relationships, i.e. social participation¹, are addressed. Irrespective of the theme that is presented, social skills are practiced when interaction is actively facilitated within the group context.

2.2 The group has a clear goal

A goal is selected according to group members' problem areas and needs. The goal can address psycho-social factors or any other underlying performance component that impacts negatively on occupational performance or participation in meaningful life roles.

2.3 An activity is presented

The term "activity" refers to any activity, task or occupation; for example games; pen-and-paper exercises; drama; drawing; participating in a craft activity; Activities of Daily Living; work. Once the occupational therapist has selected the goals for the group session, an appropriate activity(ies) is(are) selected which allows the goal to be achieved **through participation** in the activity(ies), **within** the group. Together, group members are provided an opportunity to practice selected skill(s), for example problem-solving and social skills **simultaneously within the Here-and-Now context**.

2.4 Questions are intentional and specific

The questions asked by the occupational therapist during a group, are used with a specific intention. They focus either on the problem areas identified, goal of the group selected, group dynamics displayed, specific behavior occurring **within** the group or any problem pertaining to occupational performance areas. Questions that focus on the "here-and-now" are recommended; "What?", "What impact?", "When?", "Whom in the group?" - emphasising group members' experiences within the group. These questions are powerful in that they facilitate reflection and insight into each group member's experience, problem areas and on the group dynamics, with ease, which then bridges to real life situations, informing future treatment goals.

If an occupational therapist's occupation-focused group-work meets all the above criteria, then she/he can be confident that his/her practice falls within the profession's scope and has something unique to offer patients.

3. SIGNIFICANCE OF THE POSITION PAPER TO OCCUPATIONAL THERAPY

This position paper is significant to occupational therapy as it emphasises occupation as the primary focus of practice. Clarity of occupation-focused group-work in occupational therapy, particularly in mental health settings, provides for a clearer description of role and the unique contribution made by occupational therapists in mental health care.

4. STATEMENT OF THE SIGNIFICANCE OF THE POSITION TO SOCIETY

This statement clarifies and highlights the unique contribution occupational therapists offer clients, particularly mental health care users, through occupation-focused group-work which centers on practically addressing occupational performance and/or participation in meaningful life roles.

5. CHALLENGES AND STRATEGIES

There are challenges that face the implementation of the position paper.

5.1 Dissemination and national progress

Strategies to raise awareness among occupational therapists nationally will include, among others; publication in the South African Journal of Occupational Therapy and requesting the Professional Board of Occupational Therapy, Medical Orthotics and Prosthetics and Arts Therapy, to evaluate whether the "Minimum Standards for the Training of Occupational Therapists" cover the above criteria sufficiently.

5.2 Research

Evidence-based research in occupation-focused group-work within occupational therapy practice is critical. Occupational therapy education and training programmes should encourage research in this area.

6. CONCLUSION

Occupational therapists have particular expertise and a set of skills which translate into a unique practice of group-work. Within mental health care settings, occupation-focused groups have emerged as one group practice specific to occupational therapy. While the uniqueness of occupation-focused groups transcends all areas of occupational therapy practice, community based occupational therapy -for example may have other forms of group-work not fully covered by the above guidelines. The unique characteristics of occupation-focused groups described in this position paper should give occupational therapists confidence in defining, planning, presenting and evaluating group-work as part of occupational therapy practice in all settings.

REFERENCES

1. American Occupational Therapy Practice framework. *American Journal of Occupational Therapy*. 2008; Vol 62(6): 625-683.
2. Draft Scope of Profession and Practice Document for Occupational Therapy in South Africa.
3. Yalom, I.D. *The theory and practice of group psychotherapy*. 4th ed. Basic books. New York. 1995.

ACKNOWLEDGEMENTS

- ❖ Ms Louis Fouche – the proponent for the current position statement.
- ❖ The Psychiatric Occupational Therapy (POTS) Group, OT-Grow and all occupational therapy programs in South Africa for giving input into the development of the position statement.

Date Ratified: 31/03/2014



Appendix B : Unit X Programme

Time	Monday	Tuesday	Wednesday	Thursday	Friday
07H00	Night Handover	Night Handover	Night Handover	Night Handover	Night Handover
07H15					
07H30	Feelwall Medication	Feelwall Medication	Feelwall Medication	Feelwall Medication	Feelwall Medication
07H45				Breakfast	
08H00	Breakfast	Breakfast	Breakfast		Breakfast
08H15					
08H30	Chronic illness group		OCCUPATIONAL THERAPY IGM	Craft group	Support Group
09H30		Tea		Tea	Tea
					Tea
10H00	Tea	OCCUPATIONAL THERAPY IGM			
10H15			Tea		
10H30	PT/Admin Social			Goals and tasks Midstay Evaluation	Community Meeting
10H45			Community Meeting		
11H30	Medication		Yoga	Medication	Medication
12H00	Lunch	Lunch		Lunch	Lunch
13H00	Leisure Skills	Growth Games/values	Lunch	Walk	
14H00		Walk		Adherence Group	
15H00	Tea	Tea	Tea	Tea	Tea
15H30	Relaxation			Relaxation	
17H00	Supper	Supper	Supper	Supper	Supper
20H00	Feedback	Feedback	Feedback	Feedback	Feedback
21H00	Medication	Medication	Medication	Medication	Medication
21H30	Mindfulness	Mindfulness	Mindfulness	Mindfulness	Mindfulness

Appendix C : Ethics Letter (HREC)

The letter has been removed to avoid exposing the authority's signature online.

Appendix D : PGWC Ethics



Associate Professor E. Duncan
Occupational Therapy
Department of Health & Rehabilitation
F-Floor - Old Main Building

E-mail: shanaycdavidson@gmail.com

Dear A/Professor Duncan

RESEARCH PROJECT: The Perceptions on the contribution of the Interactive Group Work Model in Occupational therapy Groups to Recovery of Mental Health Care Users (Masters – S. Davidson)

Your recent letter to the hospital refers.

You are hereby granted permission to proceed with your research which is valid until **30 October 2017**.

Please note the following:

- a) Your research may not interfere with normal patient care.
- b) Hospital staff may not be asked to assist with the research.
- c) No additional costs to the hospital should be incurred i.e. Lab, consumables or stationary.
- d) **No patient folders may be removed from the premises or be inaccessible.**
- e) Please discuss the study with the HOD before commencing.
- f) Please introduce yourself to the person in charge of an area before commencing.
- g) Please provide the research assistant/field worker with a copy of this letter as verification of approval.
- h) Confidentiality must be maintained at all times.
- i) Should you at any time require photographs of your subjects, please obtain the necessary indemnity forms from our Public Relations Office (E45 OMB or ext. 2187/2188).
- j) Should you require additional research time beyond the stipulated expiry date, please apply for an extension.
- k) **On completion of your research, please forward any recommendations/findings that can be beneficial to us to take further action that may inform redevelopment of future policy/review guidelines.**
- l) **Kindly submit a copy of the publication or report to this office on completion of the research.**

I would like to wish you every success with the project.

Yours sincerely

Appendix E : Interview protocol

“Many thanks again on agreeing to participate in this study.

Before we begin with the interview, there are a few things that I would like to inform you of: To be sure that I have a record of what has been said, I will be recording throughout the interview. The interview will be transcribed into a Microsoft word document. A transcript of the interview will be brought to the next meetings so that you are able to clarify that I have captured what has been said accurately. All the information that you share with me during these interviews is confidential, and only my supervisor and I will be listening to the interviews and reading the transcripts.”

“Would you please provide me with the following demographic information?”

Section A

Age	
Gender	
Address	
Diagnosis/ Diagnoses	
Number of previous admissions to the unit	
Number of IGM groups attended	

Section B

“The focus of the study is to describe the perspectives of service users on the contribution (or not) of occupational therapy groups to the recovery of persons with mental health concerns. By recovery, I mean anything that helps you along your journey of healing. It may involve the changing of ones attitudes, values, feelings, goals skills and roles and of gradually transforming/changing/developing a meaningful and purposeful way of living even with the limitations caused by the illness.

“To begin, would you think about the different groups you have participated in during your admission to this unit? Within the daily programme, different groups are offered such as cooking and life skills, which groups did you participate in?”

1. Having discussed the different groups you have participated in, I now want to focus specifically on one particular type of group. This is the OT group where the OT uses a warm up such a game of Jenga and a main activity such as building a Lego house as

triggers for group discussion. Can you choose one such session and start by describing what happened.

Probe: thinking about your recovery journey, what did the OT do that was helpful/not helpful?

Probe: What could s/he do to improve the benefits for you of participating in the group?

Probe: In which ways did the activities used by the OT help/not help the group to discuss their issues?

Probe: What links, if any, can you make between the things that groups members talk about as a result of the IGM activities and your functioning in everyday life /in the ward/outside the ward?

Probe: Which activity triggers were most helpful/not helpful? Why do you say that?

2. What do you think the contribution of IGM occupational therapy groups were to the people in Unit X?

Probe: What do you think occupational therapy groups are meant to assist people in the hospital with?

3. What are the benefits of/barriers to using the IGM groups?

The IGM consists of three stages. Let's talk about each stage now:

The warm up

The main activity

The discussion stage

Probe: What did you find was helpful/not helpful? Which aspects do you think worked/did not work?

4. You have already indicted some limitations of the model

Probe: What else didn't you like about the model?

What recommendations can you make to improve on these limitations/on increasing benefits of the IGM?

5. In what ways do you think the groups assisted in contributing to your recovery?

Probe: How do you think this group contributed to your: attitudes, values, feelings, goals, skills, and roles? Developing a meaningful life even in the limitations caused by illness.

6. Do you have any questions you would like to ask me?

Appendix F : Observation guide

CONCEPTS IN IGM					
STEPS IN IGM	Microcosm	Interactiveness	Direct communication	Here & now	Leading from behind
Intro					
Norm setting					
Meet group at emotional level					
Warm up					
Bridging					
Activity					
Feedback /norm setting					
Post activity discussion					
closure					

Appendix F1: Completed Observation guide

Theme: Inspiration
w/lu - Card 6.10

Appendix I: Observation guide

Date: 02/05/17

Place: Unit 2.2

Time: 10:00

STEPS IN IGM	CONCEPTS IN IGM					
	Microcosm	Interactiveness	Direct communication	Here & now	Leading from behind	
Intro						
Norm setting						
Meet group at emotional level	group starts c ins Op @ve. B + v C + v D takes group to refer to feedback E @ve	Group asked to give feedback to member who is struggling. Group gives feedback. Feedback may not want to listen, member responds across emotional levels.	Direct feedback on then participant feedback. Frustrating because you can't stand to equal.	* Direct check in check-in now emotional state to D regularly	Always needs to be the forwarder checks in Therapist	
Warm up	Building a team D + C	Group interacting with working on different levels.	* Stretch time	* Stretch time at emotional level.		
Bridging						

Start to check in of emotional level. checks, & asks reasons for negative feedback/feelings, direct questions regarding feedback.

Activity	II	III	IV	V	VI	Observations & instructions
Feedback/norm setting	Assess + active participation	Active, some participation	Group gives feedback	Group directly gives feedback. Therapist asks D to respond directly to C & G. T. acknowledges Therapist asks her to move on.		
Post activity discussion				Directly asks Jane D. J. makes reference to service.		
closure						

D takes 10 minutes for "check in" emotional level. Therapist asks the group to assist.

WU - feedback on how members find it

⑤ Did it feel meaningful. Therapist asked what ⑤ was telling herself, ⑤ verbalizes disappointment that asks ⑥ what helped her keep going even though she struggled.

Direct asking members how they felt

Asks regarding direct observations, Therapist asks group for feedback on ⑤'s turn, as ⑤ feels bad for others not succeeding and that she was able to build a successful future. Directly addresses difficulties in enjoying success/achievement. Therapist "can't feel it".

Therapist asks ⑥ if dealing with frustration, ⑥ responds Therapist asks re "maybe it was too ambitious" "the therapist asks you" "is there such a thing?" Group gives verbal feedback, group gives feedback by saying "good one loud" → "It's nice out there so everyone knows about it".

⑥ asks to direct feedback from all members.

⑤ "How will playing cards change my life?" "feels powerless" → "help + new" direct feedback from Misha re "If I can exclaim... You put the obstacles there" ⑤ agrees.

Misha receives feedback from each member on what they could do differently, Misha and her siblings, keeping in mind what they've discussed.

Main activity → building a lego house entire group one house. Rules constantly changing how participants deal

Therapist observes from outside, Misha group that can use green blocks, could use blue blocks second house from the start. 30 mins therapist sits down → group very quiet group finish ⑤ "was fun, it's interesting" ⑥ "No in no frustration"

⑤ "I noticed... everyone participated" "what did you find about today's process, 'the millionth time' repetition therapist acknowledges but says that the constraint is "you", relates isolating + withdrawing behavior. in group to life "yes I do it everywhere" relates to previous feedback re recovery. in group "you do you have the answer"

"I don't want feedback" "You don't have a choice" "what makes it difficult to hear feedback?"

"the truth" "what's difficult about the truth, group provides feedback ⑤ agrees that Misha asks group to give feedback on helping D to cope? or else she's struggling Misha gives feedback to D Asks where the rest of the group is at.

Energy low

Asks group to reflect, on goals

⑤ reflects on group, mood changed Misha gives feedback, "I can't take it quite seriously reflects on mood & asks if she was able to express it

⑤ asks a ⑥ → says it happens a lot, ⑥ why are you crying

⑤ says "I can't say it happens often but face + ⑥ says differently "You don't say anything" ⑥ says that "I may be imitating, but you never say anything"

⑤ says "I'm just rather say using Misha what makes it hard for you to say anything uses group to give feedback, re if PT gives feedback, group agrees ⑤ "what would you like to say to me"

"30 mins. What are you taking away from session check out...


Therapist gives feedback at clarifies ⑤ participants saw

21 30
12 36, 01, 1
10 45, 1, 1
10 45, 1, 1
15 48 45
16 45
17 30

⑤

19. 1. 8

Appendix G : Informed consent (Pilot study)

	<p>Department of Health and Rehabilitation Sciences Faculty of Health Sciences Divisions of Communications Sciences and Disorders, Physiotherapy F45 Old Main Building, Groote Schuur Hospital, Observatory 7925. Tel: +27 (0) 21 406 6401 Fax: +27 (0) 21 406 6323 Internet: www.uct.ac.za</p>
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*translated into Afrikaans using the University language department & tested in the pilot study

INFORMATION SHEET (Pilot Study)

RESEARCHER: Shanay Davidson

SUPERVISORS: Associate Professor Eve Duncan and Ms Matumo Ramafikeng

Dear Participant

My name is Shanay Davidson and I am student at the University of Cape Town. I am conducting research as part of the Masters in Occupational Therapy degree.

The title of the research is “The perceptions on the contribution of the Interactive Groupwork Model in occupational therapy groups to recovery of mental health care users”.

The Interactive Groupwork Model (IGM) is a particular way in which occupational therapists run some groups in the therapeutic programme of the ward where you are currently being hospitalised. Mental health service providers should evaluate the treatment methods that occupational therapists use to make sure that their services are people centred. One way of evaluating a service is by asking service users their opinions about particular aspects of their treatment. I therefore want to know what you think about the groups in which the IGM is used and the contribution (or not) of these particular group sessions to your recovery. In summary, the study wants to know what you think about the Interactive Groupwork Model in occupational therapy groups. It is hoped that this study will help occupational therapists improve their service in mental health treatment units where the IGM is used. You have been approached to participate in this study as you have participated in groups where the IGM was used. This is the pilot study and will be used to inform the future changes in the study related to this form and the interview process. The pilot study will require you to participate in one interview of approximately 40 minutes.

It is important that you clearly understand what participating in this pilot research interview entails and how you will be involved. The interview will be tape recorded. You will be required to give your consent and permission that the information provided by you can be used for the research purpose. Your participation is entirely voluntary and there is no penalty for not answering questions or stopping the interview at any time. You are free to decline to participate and if you say no, this will not affect you negatively in any way.

All the information collected will be treated as confidential. You will be given or may choose your own pseudonym (a fictitious name) so that you can talk freely without being recognised. Only my supervisors and I will have access to any personal information. Your identity will remain anonymous and the use of pseudonyms will be carried through should the research be published. Your hospital file will not be consulted during the research process.

There are some risks involved in participating in the study. You may become tired during the interview. You may feel uncomfortable sharing your opinions regarding the IGM and how being a member of a group in which it is used affects you and your recovery journey. Opinions that are favourable, neutral or not favourable are welcome. You will not receive compensation for participating in the study although you might find that you derive some benefit from telling your story of your group therapy

experience and what you think about occupational therapy groups in particular. If you feel distressed during the interview process, you may take a break or stop the interview. An appointment will be made for you to see the mental health nurse or psychologist on the unit if you find that the interview has in any way affected you negatively.

Please contact me directly with any research related questions. I am available on (021) 440 3219

This research will be supervised by Associate Professor Eve Madeleine Duncan & Ms Matumo Ramafikeng. They can be contacted on 021 406 6325. Dr Mark Blockman of the Faculty of Health Sciences Human Research Ethics Committee can also be contacted 021 4066340

This research has been approved by the Research Ethics Committee and its reference number is 599/2016

Please indicate that you understand what is required of you and that you are willing to participate by completing the biographical data grid and signing the consent form on the following page.

INFORMED CONSENT FORM

Declaration by interviewee: Please tick in box

- ☐ I _____ have read the Information Sheet
- ☐ I understand what is required of me and I have had all my questions answered.
- ☐ I agree to participate in the research “The perceptions on the contribution of the Interactive Groupwork Model in occupational therapy groups”.
- ☐ I am freely participating the study and am aware that I can withdraw at any given time without penalty.

Signed:

Participant

Date and place

Declaration by interviewer

I, Shanay Davidson (DVDSHA022) declare that:

- I explained the information on the research to the participant.


- I encouraged them to ask questions and took adequate time to answer them.
- I am satisfied that they adequately understand all aspects of the research as discussed above
- I did not use a translator

Signed at (place) On (date)

2016.

Signature of researcher.....

Appendix H : Participant Consent Form

	<p>Department of Health and Rehabilitation Sciences Faculty of Health Sciences Divisions of Communications Sciences and Disorders, Physiotherapy F45 Old Main Building, Groote Schuur Hospital, Observatory 7925. Tel: +27 (0) 21 406 6401 Fax: +27 (0) 21 406 6323 Internet: www.uct.ac.za</p>
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*translated into Afrikaans using the University language department & will be tested in the pilot study

INFORMATION SHEET RESEARCHER: Shanay Davidson

SUPERVISOR: Associate Professor Eve Duncan & Ms Matumo Ramafikeng

Dear Participant

My name is Shanay Davidson and I am student at the University of Cape Town. I am conducting research as part of the Masters in Occupational Therapy degree.

The title of the research is “The perceptions on the contribution of the Interactive Groupwork Model in occupational therapy groups to recovery of mental health care users”.

The Interactive Groupwork Model (IGM) is a particular way in which occupational therapists run some groups in the therapeutic programme of the ward where you are currently being hospitalised. Mental health service providers should evaluate the

treatment methods that occupational therapists use to make sure that their services are people centred. One way of evaluating a service is by asking service users their opinions about particular aspects of their treatment. I therefore want to know what you think about the groups in which the IGM is used and the contribution (or not) of these particular group sessions to your recovery. In summary, the study wants to know what you think about the Interactive Groupwork Model in occupational therapy groups. It is hoped that this study will help occupational therapists improve their service in mental health treatment units where the IGM is used. You have been approached to participate in this study as you have participated in groups where the IGM was used. The study will involve three individual interviews of approximately 40 minutes duration each; one at the beginning stage of your treatment in the unit in week two (soon after your first exposure to IGM), one at the end of your treatment period in week 8 (after repeated exposure to the IGM) and one interview approximately one month after discharge. The same interview schedule will be used at all three interviews.

It is important that you clearly understand what participating in this research entails and how you will be involved. Each interview will be tape recorded. You will be required to give your consent prior to each interview and permission that the information provided by you can be used for the research purpose. Your participation is entirely voluntary and there is no penalty for not answering questions or stopping the interview at any time. You are free to decline to participate and if you say no, this will not affect you negatively in any way.

All the information collected will be treated as confidential. You will be given or may choose your own pseudonym (a fictitious name) so that you can talk freely without being recognised. Only my supervisors and I will have access to any personal information. Your identity will remain anonymous and the use of pseudonyms will be carried through should the research be published. Your hospital file will not be consulted during the research process.

There are some risks involved in participating in the study. You may become tired during the interview. You may feel uncomfortable sharing your opinions regarding the IGM and how being a member of a group in which it is used affects you and your recovery journey. Opinions that are favourable, neutral or not favourable are welcome. You will not receive compensation for participating in the study although you might find that you derive some benefit from telling your story of how your experience and

what you think about occupational therapy groups. If you feel distressed during the interview process, you may take a break or stop the interview. An appointment will be made for you to see the mental health nurse or psychologist on the unit if you find that the interview has in any way affected you negatively.

Please contact me directly with any research related questions. I am available on (021) 440 3219

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INFORMED CONSENT FORM

Declaration by interviewee

- ☐ I _____ have read the Information Sheet.
- ☐ I understand what is required of me and I have had all my questions answered.
- ☐ I agree to participate in the research “The perceptions on the contribution of the Interactive Groupwork Model in occupational therapy groups”.
- ☐ I am freely participating the study and am aware that I can withdraw at any given time without penalty.

Signed:

Participant

Date and place

Declaration by interviewer

I, Shanay Davidson (DVDSHA022) declare that:

- I explained the information on the research to the participant.
- I encouraged them to ask questions and took adequate time to answer them.
- I am satisfied that they adequately understand all aspects of the research as discussed above

- I did not use a translator

Signed at (place) On (date)
2016.

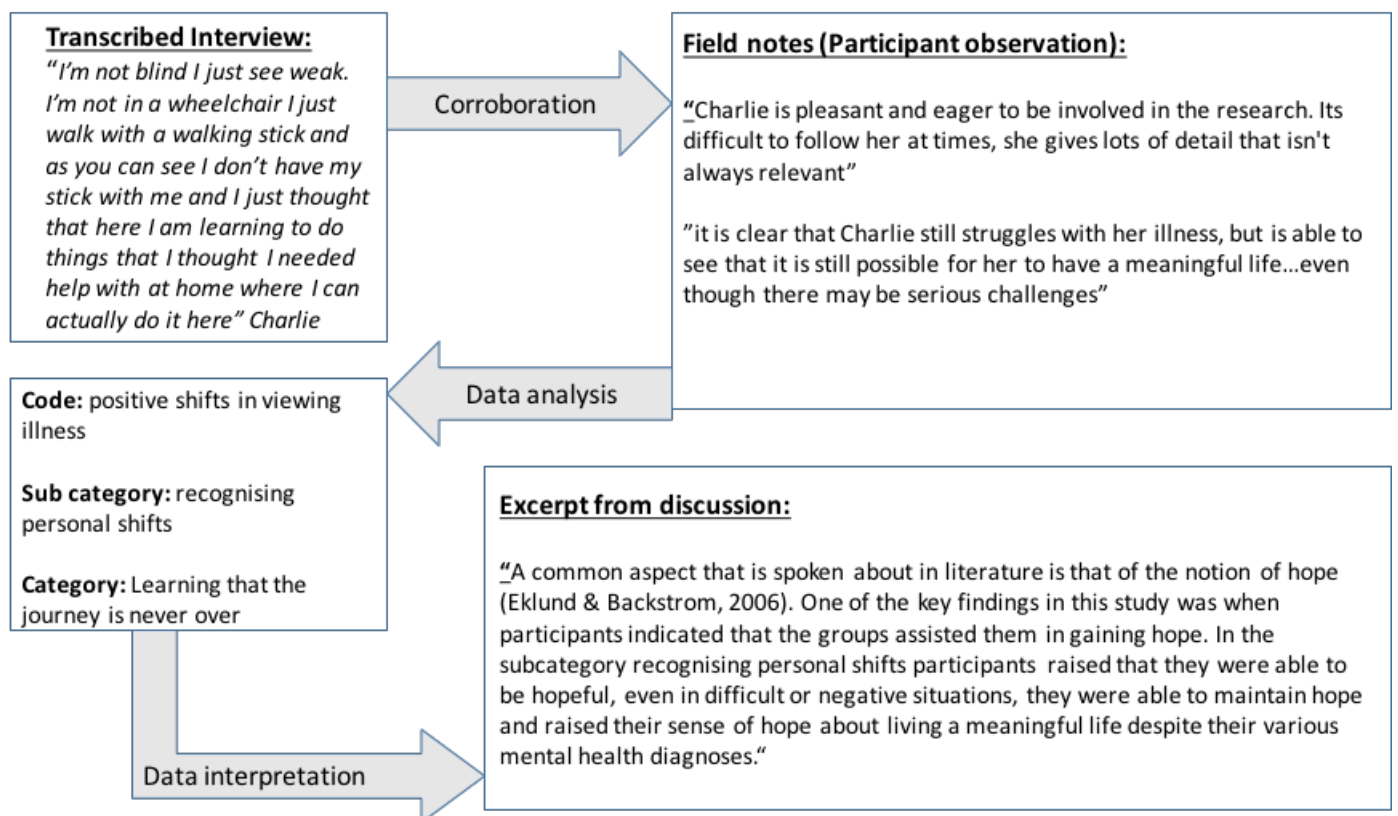
Signature of researcher.....

Appendix I : Data Spiral

Data management	Data files created and organized. Manual and electronic copies of transcripts created
Reading and memoing	I immersed myself into the data by reading the transcripts multiple times whilst making side notes. This assisted in highlighting key points that arose from the data. This process resulted in the identification of codes.
Describing	A brief description of each participant was written including basic demographics, admissions to the unit, diagnosis and impressions.
Classifying	Codes were grouped into subcategories. Subcategories that overlapped were grouped into categories. Throughout this process I remained open to the possibility of additional categories as I worked. I followed this process until saturation was reached. The data was 'winnowed' (Creswell, 2007, p. 185), as not all of the information gathered could have been included in the study. Categories were examined and combined into an overarching themes This theme, categories and subcategories were used to write up the findings chapter.

Interpreting	Data was interpreted in a cyclic and not linear manner, as it was a process where I engaged in a cross-case analysis looking for knowledge, which could have contributed to research literature and the growing body of knowledge.
Representing and visualising	The findings were represented in chapters 4 (findings) and 5 & 6 (discussion and conclusion) through the use of verbatim quotes and tables. Member checking was used to validate the findings throughout the process.

Appendix J : Visual diagram



Appendix K : Journal Excerpt

24 April 2016

“Today was interesting, lots of thoughts! Both Lucy and Monique index admissions to the unit. The feeling I get from them is very different. Lucy is very positive about the unit and the model, and seems uncomfortable giving negative feedback about the model. It feels like she’s holding back and wanting to please me. Lucy appears lighter and more positive...”

“Monique seems confident and comfortable to share the positive as well as the negative aspects of the model. This is the second interview for both of them, but Monique feels disappointed that she isn’t getting better. It’s never one size fits all, but I wonder what the difference in experience are about?”

Appendix L : Audit trail element

Audit Trail Element	Examples	Activities
Raw data	Audi data, interview transcriptions, observation notes, reflexive journal notes	Early emersion in the data Suspension of personal assumptions Triangulation of data generation methods
Data reduction and analysis	Summaries, ideas and notes on emergent concepts, margin notes on transcripts	Triangulation through confirmation of findings and the deterrence of assumptions surfacing during the process
Data reconstruction and synthesis	Organisation of theme, categories and subcategories Documentation of findings based on interpretations and suggestions Writing of discussion and recommendations based on relations with existing literature	Ensuring the voice of the participants came through for the participants Interaction with peers and university supervisors and support Member checking
Process notes	Research design chapter, as well as audit trail to ensure	Manual organisation of different elements of the research

	trustworthiness and authenticity	
Material related to intention	Research proposal, ethics approval, consent forms, reflexivity journal	Documents found in appendices
Instrument development	Pilot interview, interview questionnaire, draft reports and feedback notes	Interview questionnaire revised after pilot interview process